1 IN THE CHANCERY COURT OF JACKSON COUNTY,
MISSISSIPPI
2 CAUSE NO. 94-1429

3
IN RE MIKE MOORE, ATTORNEY GENERAL
4 EX REL, STATE OF MISSISSIPPI
TOBACCO LITIGATION
5

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12 DEPOSITION OF: EDWARD N. WILLEY, M.D.

13 DATE: March 27, 1997

14 TIME: 10:05 a.m.

15 LOCATION: Heritage Holiday Inn
256 2nd Street North
16 St. Petersburg, Florida 33701

17
TAKEN BY: Counsel for the Plaintiff
18
REPORTED BY: DONNA L. PETERSON
19 Registered Professional
Reporter, CP, CM, RDR
20

21 ---

22 Computer-Aided Transcription By:

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20 (INDEX AT REAR OF TRANSCRIPT)

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(Exhibit Nos. 1 through 4 were marked for identification.)

MR. WOHNER: This deposition shall be governed by paragraph 13 of the order governing access to and use of materials determined to be privileged and/or confidential. That means that the entire transcript and exhibits will remain confidential for a period of 14 days after the date the deposition transcript is received. Within those 14 days we will designate the specific exhibits and/or pages and lines of the transcript that we believe to be confidential material and notify the parties.

MR. WESTBROOK: And before we get started with the questioning of the doctor, I have had the court reporter mark, to save some time, some of the introductory exhibits. Exhibit 1 is the notice of deposition in this case.

MR. SHEPPARD: All right.

MR. WESTBROOK: Exhibit 2 is the amended case management order which governs the conduct of this case, including the depositions, paragraphs beginning paragraphs 15 and running through paragraphs 20 concerning depositions, including paragraph 16 which states, quote, "There shall be no speaking objections",

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1 unquote, at the depositions.

2 Exhibit 3 is a letter dated March 25th,

3 1997 from the Shook, Hardy firm to me, accompanying the

4 production of documents that is responsive or in

5 response to our notice of deposition and document

6 request.

7 And Exhibit 4 is Dr. Willey's Rule 26

8 disclosure statement and curriculum vitae.

9 Doctor, good morning. My name is Edward

10 Westbrook, and I represent the State of Mississippi in

11 a lawsuit that it has brought against the tobacco

12 companies. And I will be asking you questions today,

13 doctor. And if you don't understand the question,

14 please ask me, and I will try to rephrase it so we are

15 communicating.

16 THE WITNESS: I will try to do that.

17 MR. SHEPPARD: Thank you. Would you swear

18 the witness, please.

19 EDWARD N. WILLEY, M.D.

20 being first duly sworn, testified as follows:

21 EXAMINATION

22 BY MR. WESTBROOK:

23 Q. Doctor, would you please give your full

24 name and address for the record?

25 A. Edward N., as in "now", Willey,

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1 W-i-l-l-e-y. My office address is [DELETED]
2
3 Q. And what is your Social Security number,
4 sir?
5 A. [DELETED]
6 Q. And, doctor, you are a medical doctor, an
7 M.D.?
8 A. Yes.
9 Q. Doctor, in the normal course of your
10 practice do you treat patients?
11 A. Generally not.
12 Q. When was the last time that you regularly
13 treated patients in your medical career?
14 A. I don't believe I have ever regularly
15 treated patients unless you construe that in some very
16 broad manner.
17 Q. Okay. When you finished medical school,
18 sir, did you serve an internship or residency at a
19 hospital?
20 A. Yes.
21 Q. During that period were you regularly
22 treating patients in the hospital?
23 A. No.
24 Q. Have you ever, since you finished an
25 internship or residency, doctor, examined a human being

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1 to make a diagnosis of disease?
2 A. Yes.
3 Q. Okay. And by examining human being, I am
4 talking about the person himself rather than tissue in
5 a laboratory. Do you understand that distinction?
6 A. I believe so.
7 Q. Okay. And have you on occasion examined,
8 that is the person himself as opposed to tissue, in
9 order to make a diagnosis?
10 A. I presume that doing autopsies is a
11 relevant examination of a person. Is that what you
12 have in mind?
13 Q. Okay. Let's back up. Before death. I
14 should be more specific. Have you ever examined a
15 person in life in order to make a diagnosis?
16 A. Yes.
17 Q. Okay. Do you do that regularly?
18 A. No.
19 Q. All right, sir. Dr. Willey, do you
20 understand that this case is about cigarettes, tobacco
21 and related matters?
22 A. In general I understand that.
23 Q. All right. Doctor, in your view is
24 cigarette smoking good for anybody's health?
25 MR. SHEPPARD: Object to the form as vague,

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1 general and unspecific, outside of his disclosure
2 statement.
3 A. Well, I don't really have very much in the
4 way of judgments about smoking. I don't recommend it.
5 I don't think it improves one's health.
6 Q. All right. In your opinion, doctor, can
7 cigarette smoking cause disease?
8 MR. SHEPPARD: I just want to object as
9 vague and general, outside the scope of his disclosure
10 statement.
11 A. I don't really have judgments about
12 causation that are substantive in this matter. That's
13 not what I was engaged to do.
14 Q. I understand. I understand that. I'm
15 asking you, as a medical doctor and from your
16 experience of some odd decades in the medical
17 profession, is it your view or not that cigarette
18 smoking can cause disease?
19 MR. SHEPPARD: Same objection.
20 A. Well, certainly cigarette smoking may be
21 associated with the ultimate development of disease,
22 yes.
23 Q. All right. And what diseases would you put
24 in the category of those that may be associated with
25 cigarette smoking in some way?

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1 A. Well, I bring no special expertise to that,
2 and I don't really have judgments about it. The
3 literature indicates that respiratory diseases and
4 malignancies are in some cases associated with that.
5 Q. Would you include lung cancer among the
6 malignancies that are associated with cigarette
7 smoking?
8 A. Yes.
9 Q. All right. Would you include emphysema
10 among the diseases associated with cigarette smoking?
11 A. Yes.
12 Q. Would you include heart disease among the
13 diseases associated with cigarette smoking?
14 A. Possibly.
15 Q. Doctor, have you written any medical or
16 scientific articles concerning cigarette smoking and
17 disease?
18 A. No.
19 Q. All right. Doctor, I take it from
20 reviewing your C.V. that you have been deposed on a
21 number of occasions before, is that right?
22 A. Yes.
23 Q. Have you ever been involved before in a
24 case that involved cigarette smoking and disease?
25 A. Possibly, but I don't recall one. Both

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1 disease and cigarette smoking are quite common. It
2 would be surprising, in looking at many cases, that
3 there wasn't some association; but I do not recall that
4 that was a relevant consideration.
5 Q. Okay. Is there any general type of case
6 that you have consulted in more than others that you
7 could give me an example of, such as I consulted DUI
8 cases or I consulted breast cancer cases? Can you make
9 any type of generalization like that?
10 A. No. I would say that the only case, set of
11 cases that I have had that have substantial common
12 denominators are criminal cases, assaults, homicides,
13 abuse of one sort and another, things of that
14 character.
15 Q. When you are speaking about abuse, are you
16 talking about physical abuse?
17 A. Physical abuse. I am not really well
18 prepared as a pathologist to deal with emotional abuse.
19 Q. All right. I was really distinguishing
20 between physical abuse and drug abuse. Simply
21 referring to drug abuse, have you been involved in drug
22 abuse cases?
23 A. Some, certainly. Not a large number.
24 Q. All right. Doctor, are you familiar with
25 any of the recognized effects of nicotine on the body?

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1 A. No. I have never made any study of
2 nicotine on the body.
3 Q. Have you made any study of the effects of
4 cocaine on the body?
5 A. No.
6 Q. Doctor, what is a hematologist?
7 A. Well, there are probably as many
8 definitions as there are hematologists. But I think of
9 a hematologist as a specialist in blood diseases. And
10 there are various tracks by which they arrive at that
11 position.
12 Q. Okay. Have you ever held yourself out or
13 considered yourself to be a hematologist?
14 A. Not to my recollection. There may be
15 someone that has interpreted me as a hematologist, but
16 that's not what I consider myself to be.
17 Q. What is an oncologist, sir?
18 A. Well, the same general statement must be
19 made about oncologists because there are many different
20 definitions of oncology. And the person that's a
21 practitioner of that, the oncologist, generally
22 speaking I would say that that is a person that in some
23 way specializes in the treatment of tumors,
24 malignancies usually.
25 Q. Okay. Do you consider yourself to be an

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1 oncologist in your practice?

2 A. I really am not a person that treats

3 patients for tumors, and therefore I would say that I

4 am not an oncologist. There may be some special

5 circumstance in which someone has considered me as

6 having information relevant about that, but I certainly

7 don't remember an occasion that comes to mind.

8 Q. All right. And what is an epidemiologist

9 as you understand it, sir?

10 A. Okay. The same general statement, that

11 there are many different definitions of epidemiology.

12 But I think of that as a person that studies the

13 distribution of disease on the basis of population

14 information.

15 Q. Have you ever conducted an epidemiological

16 study of any sort?

17 A. I can't say no, because I don't have a

18 recollection of everything I have ever done. And it

19 would appear likely that I have done some modest

20 epidemiological studies for infectious disease because

21 that's something that pathologists at hospitals do, but

22 I don't specifically remember a circumstance.

23 Q. All right. When you say that it seems

24 likely that you have done some modest epidemiological

25 studies, do you have a recollection of ever looking at

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1 a large number of case histories and attempting to
2 determine, for instance, the association between the
3 disease shown in those case histories and various
4 factors?
5 A. Well, what do you mean by a large number?
6 Q. Well, more than a hundred.
7 A. No.
8 Q. Are you familiar with the term as
9 epidemiologists use it concerning the, quote, "power",
10 unquote, of a study?
11 A. No. It sounds like that may be some
12 statistical test.
13 Q. Okay. And I take it you are not a
14 statistician?
15 A. You take it correctly.
16 Q. All right. And, doctor, is there another
17 specialty within medicine and science called
18 toxicology?
19 A. Yes.
20 Q. All right. And practitioners of that are
21 normally referred to as toxicologists?
22 A. I believe so.
23 Q. Okay. And what is toxicology?
24 A. Okay. Toxicology also takes many different
25 forms. I think of a toxicologist as a chemist that

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1 generally in my experience does determinations for
2 drugs or poisons. And/or poisons.
3 Q. When you say does determinations, you are
4 referring to attempting to discover whether there are
5 drugs or poisons in a person's system, for instance?
6 A. Yes.
7 Q. Okay. Have you ever published any articles
8 on toxicology?
9 A. I don't believe so. I certainly don't have
10 any recollection of anything I have published that I
11 would characterize as a study in toxicology.
12 Q. Now, you are a pathologist, correct, sir?
13 A. Yes.
14 Q. All right. Are there various
15 subspecialties of pathology?
16 A. Yes.
17 Q. And what are they?
18 A. Oh, I can't possibly tell you all of them
19 because they are continuously in evolution. Among
20 those that are commonly recognized that have
21 independent certification, there is anatomical
22 pathology, clinical pathology and forensic pathology.
23 But there are a number of subdisciplines that also have
24 that type of recognition. And there are pathologists
25 that have other specialties that are recognized, which

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1 there are relatively few practitioners, for which there
2 is no training or certification. A case in point would
3 be a pathologist who specializes in the examination of
4 the placenta.
5 Q. Okay. Let's take the three major
6 subspecialties in pathology. Could you tell me what a
7 clinical pathologist is?
8 A. That's a difficult question to answer. I
9 can't answer it in full scope because there are a large
10 number of different types of people that practice
11 clinical pathology, those that do nothing except
12 supervise and those that do nothing except work in some
13 particular aspect of what they define as clinical
14 pathology. But generally speaking, those are people
15 that do work and provide supervision in laboratory
16 aspects of medicine.
17 Q. In the laboratory aspects of medicine. All
18 right.
19 A. Yes.
20 Q. And, then, what is an anatomical
21 pathologist?
22 A. An anatomical pathologist is effectively
23 where pathology originally began, is the examination of
24 bodies, tissues and cells.
25 Q. If I am a pathologist and I am examining

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1 tissue to determine whether it's a malignant tumor or
2 not, what type of pathology am I practicing there?
3 A. That's generally considered to be part of
4 anatomical pathology.
5 Q. All right. And then you identified a third
6 type of pathologist; that is a forensic pathologist.
7 What does a forensic pathologist do in general?
8 A. Well, they largely do the same thing as
9 anatomical pathologists do, but their function
10 generally involves information collected to solve
11 problems of one sort, particularly those that relate to
12 legal issues. The common manner of employment of
13 forensic pathologists is as medical examiners.
14 Q. All right. Have you specialized in any of
15 these three subspecialties in pathology?
16 A. No. I consider myself a general
17 pathologist, and I have done things in all of those
18 areas.
19 Q. Okay. Could you elaborate a bit more on
20 the clinical pathologist? You mentioned that he or she
21 would be involved in the laboratory aspects of
22 medicine. Give me some examples of what you mean by
23 that.
24 A. Well, in my own case, I supervised a blood
25 bank for some 18 years and provided consultation and

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1 analysis of information and blood banking generally.
2 But it's quite broad. It might be chemistry. It might
3 be gas analysis. It could be hematology.
4 Q. All right.
5 A. Some pathologists consider themselves to be
6 hematologists.
7 Q. All right. Have you ever been a medical
8 examiner?
9 A. Yes.
10 Q. Okay. When was that?
11 A. From approximately mid 1963 through mid
12 1967.
13 Q. And where did you serve as medical
14 examiner?
15 A. In Florida.
16 Q. Okay. Where in Florida, sir?
17 A. Jacksonville and several surrounding
18 counties.
19 Q. All right. As part of your duties as
20 medical examiner, did you sometimes have to determine
21 the cause of death in cases?
22 A. Yes.
23 Q. Did you have guidelines under which you
24 operated to determine the cause of death in cases?
25 A. I don't recall any.

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1 Q. All right. As medical examiner, did you
2 ever determine the cause of death without an autopsy?
3 A. Yes.
4 Q. Did you ever determine the cause of death
5 without an autopsy in a case where the cause was not
6 visually apparent from looking at a body?
7 A. I am sure I did, but I don't recall such a
8 circumstance.
9 Q. For instance, if somebody has got a bullet
10 hole through their heart, it is not hard to tell what
11 the cause of death was in that circumstance; is that
12 right?
13 A. Generally speaking that sounds like a
14 correct statement. There may be circumstances in which
15 it is not correct.
16 Q. Okay. But in cases, for instance, where a
17 body may be found lying on the sidewalk with no
18 apparent trauma, you would have to do a more intensive
19 investigation, would you, in that case?
20 A. It depends upon the circumstances, but it
21 sounds like that would be a reasonable expectation.
22 Q. Are there circumstances where the laws of
23 the State of Florida, where we are sitting, require an
24 autopsy to be performed by the medical examiner?
25 A. Well, that's a specific question about

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1 the -- the act. And I have not seen that in some time
2 so I am not sure I can meaningfully address that. My
3 belief is that it offers the opportunity, but does not
4 actually mandate that one be done.
5 Q. Okay.
6 A. My belief is subject to correction on the
7 basis of inspection of the statute as published.
8 Q. When you were the medical examiner, did you
9 do your best within the limits of your professional
10 competence to determine a correct cause of death?
11 A. I am sure that I did as well as I could do
12 with the available time and the constraints and things
13 of that sort. I don't know what you mean by the best.
14 It sounds like that could be an endless task.
15 Q. When you were working to determine the
16 cause of death in a particular case, did you go far
17 enough in your investigation in every case to satisfy
18 yourself to a reasonable degree of medical certainty
19 that the cause of death you stated was correct?
20 A. I don't know how to answer that question.
21 I can recall having occasionally certified a death as
22 undetermined.
23 Q. All right. And in that particular --
24 A. And -- excuse me.
25 Q. Go ahead.

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1 A. Sorry. You want to abandon that question?
2 Q. No, no. Continue, please.
3 A. If undetermined, I don't think that I
4 necessarily could have exerted my best to arrive at a
5 diagnosis because the diagnosis was not any of the
6 recognized causes of death.
7 Q. All right. And what percentage of cases
8 approximately that you examined as a medical examiner
9 did you list the cause of death as undetermined?
10 A. I don't remember.
11 Q. Was it a large percentage?
12 A. No.
13 Q. Would it be a very small percentage?
14 A. I don't know what you mean by very small.
15 But it's certainly, I would believe, less than
16 10 percent.
17 Q. Okay. Doctor, do you smoke?
18 A. No.
19 Q. Have you ever smoked cigarettes?
20 A. Yes.
21 Q. All right. When did you begin smoking
22 cigarettes?
23 A. It's difficult to remember, but probably
24 sometime in the early twenties.
25 Q. All right. How old approximately were you

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1 when you started?

2 A. I repeat that. That's how old I was.

3 Sometime in the early twenties.

4 Q. Oh, I am sorry. I misunderstood you, sir.

5 A. Nice of you to construe it that way

6 but. . . I like to feel distinguished.

7 Q. Do you recall why you started smoking?

8 A. No.

9 Q. How long did you smoke cigarettes?

10 A. I don't really recall. Not very long.

11 Q. All right. Why did you stop?

12 A. I considered that it was not something I

13 wanted to do.

14 Q. All right. Did you consider that it might

15 be bad for your health?

16 A. Yes.

17 Q. Okay. Have you ever smoked cigars?

18 A. Yes.

19 Q. All right. Do you presently smoke cigars?

20 A. I can't even remember the last time I

21 smoked a cigar. It's certainly been years.

22 Q. Okay.

23 A. I don't feel I have ever quit smoking

24 cigars. I just don't smoke them.

25 Q. Okay. When you smoked cigars, do you

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1 recall, doctor, whether you inhaled the cigar smoke
2 into your lung or not?
3 A. I think it's difficult to breathe and not
4 inhale to some extent, but I didn't make a conscious
5 effort to smoke by inhaling.
6 Q. And you say you can't remember when you
7 last had a cigar. Would it be more than five years ago
8 that you last had a cigar?
9 A. Definitely.
10 Q. Would it be more than 10 years ago?
11 A. I don't know.
12 Q. Were you ever what you would call a regular
13 cigar smoker?
14 A. I don't know what you mean by regular. You
15 mean on a continuing regular basis?
16 Q. Let's say two cigars a week.
17 A. No.
18 Q. Does the fact that you haven't smoked
19 cigars in at least five years have anything to do with
20 concern that cigars may be hazardous to your health?
21 A. No.
22 Q. Do you believe that cigars may be hazardous
23 to your health?
24 A. Certainly they may be.
25 Q. Have you ever smoked a pipe, sir?

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1 A. Yes.
2 Q. When did you start smoking a pipe?
3 A. Sometime in my early twenties.
4 Q. Okay. Was that during the time that you
5 were smoking cigarettes?
6 A. Well, not on the same occasions, but during
7 the same general time frame, yes.
8 Q. All right. And how long did you continue
9 smoking the pipe?
10 A. Several years.
11 Q. Okay. Did you quit pipes about the same
12 time that you quit cigarettes?
13 A. If I recall correctly, I stopped smoking a
14 pipe somewhere earlier.
15 Q. Okay. Have you smoked a pipe since you
16 quit a few years after starting in your early twenties?
17 A. Not to my recollection.
18 Q. Okay. Have you ever chewed tobacco, sir?
19 A. No.
20 Q. Have you ever used snuff?
21 A. No.
22 Q. Do you know what nicotine is?
23 A. Yes.
24 Q. What is nicotine?
25 A. Nicotine is a chemical.

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1 Q. Does nicotine have pharmacological
2 properties?
3 A. Yes.
4 Q. And what are those?
5 A. I would refer to a standard textbook to
6 describe those.
7 Q. Okay. Have you read standard textbooks
8 that describe the effects of nicotine on the body?
9 A. Yes. But I have not done so recently, and
10 I don't have a clear recollection of the pharmacology
11 of nicotine.
12 Q. Okay. Well, as far as you recall, what do
13 you recall the effects of nicotine are on the body?
14 A. I think my recollection is that nicotine
15 causes a vascular constriction.
16 Q. Okay. Do you recall any other effects?
17 A. No.
18 Q. Now, are you married, doctor?
19 A. No.
20 Q. Do you have any children, sir?
21 A. Yes.
22 Q. Okay. Do your children smoke?
23 A. Yes.
24 Q. Did your children smoke in the home when
25 they were growing up with you?

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1 A. Well, not when I was there, is my best
2 recollection.
3 Q. Did you have any formal or informal policy
4 on smoking in your home?
5 A. I don't recall either. I attempted to
6 discourage them from smoking, but I felt that was their
7 choice to make. I did not wish them to smoke in the
8 house.
9 Q. Did any of your children start smoking
10 before age 18?
11 A. Well, I don't have a clear knowledge of
12 when they began smoking because they never volunteered
13 it to me and I never asked them.
14 Q. How about today, doctor, do you permit
15 smoking in your home?
16 A. No.
17 Q. And why is that, sir?
18 A. A number of reasons. I find it
19 irritating. And it's a difficult problem to clean up
20 after it.
21 Q. Do you have any concern about the health
22 effects of what is called side stream or environmental
23 smoke?
24 A. Do I have concern about it? I really don't
25 think about that very much. I assume that that's a

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1 relevant consideration.

2 Q. All right. When you go into a restaurant

3 and the host or hostess says, smoking or nonsmoking,

4 doctor, do you always ask for nonsmoking?

5 A. As a general rule, yes. Not always.

6 Q. Do you have a policy on smoking in your

7 medical office, sir?

8 A. Well, you were misled. I do not have an

9 office where patients come. I simply have an office

10 where I do consultation.

11 Q. All right. Is that an office in your home,

12 sir?

13 A. No.

14 Q. Okay. So you have a separate office?

15 A. Yes.

16 Q. Okay. And do you permit smoking in your

17 office?

18 A. No.

19 Q. Do you have any employees other than

20 yourself?

21 A. Yes.

22 Q. And what types of employees do you have

23 there?

24 A. I have a nurse. And I have a clerical

25 person. I am not sure I have ever defined a title.

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1 And I have a transcriptionist, although she does very
2 little work in the office. I have an office cat too.
3 Q. Okay. And are all your employees aware of
4 your policy of no smoking in your office?
5 A. I presume so.
6 Q. Do you have privileges at any hospital
7 presently?
8 A. Yes.
9 Q. Okay. And what hospital do you have
10 privileges at?
11 A. The Palms, P-a-l-m-s, of Pasadena,
12 P-a-s-a-d-e-n-a, Hospital.
13 Q. And do you regularly practice your
14 profession at the Palms of Pasadena Hospital?
15 A. Not regularly.
16 Q. Okay. On occasions when you do practice,
17 what do you do in connection with the hospital?
18 A. I utilize their service.
19 Q. Okay. And what way?
20 A. I either consult with physicians there or I
21 have them provide a service.
22 Q. Do you have a laboratory in your office,
23 sir?
24 A. I guess that's probably a question directed
25 at licensure. I certainly have no laboratory of the

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1 type that you think of. I, for example, do not do wet
2 chemistry or even urinalysis or things of that
3 character.
4 Q. Do you perform any type of diagnostic
5 testing in your office?
6 A. I examine slides with a microscope.
7 Q. Do you stain tissue in your office?
8 A. No.
9 Q. Do you perform any other analytical
10 procedures, other than looking at slides under the
11 microscope in your office?
12 A. If I do, they are very trivial and they are
13 only on rare occasions. I don't specifically remember
14 a circumstance, but I'm sure in the past I have done
15 something.
16 Q. If you have to do a more involved analysis
17 of tissue or sample, do you use the Palms of Pasadena
18 Hospital facilities?
19 A. If it's within their scope, yes.
20 Q. Well --
21 A. If it is not within their scope, no.
22 Q. If it is within their scope, do you
23 normally do the analysis yourself or do you send it
24 over to the hospital pathologist for workup?
25 A. Neither one. I think perhaps you are

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1 misled. The way in which I would use them is, for
2 example, to refer a patient for a urinalysis or a
3 culture, a blood test or something like that, chemistry
4 test. And neither the pathologist, nor I, provides
5 that service. It's a technical support function.
6 Q. All right. You said you might refer a
7 patient to the hospital for these tests?
8 A. Yes.
9 Q. On what types of occasions would you be
10 seeing a patient in your office which would result in a
11 need for a referral?
12 A. Occasionally I will have patients that are
13 referred to me for solution of a problem, and part of
14 the solution of the problem may be some form of
15 testing.
16 Q. Are these referrals to you outside of the
17 litigation context, sir?
18 A. There may be potential litigation or
19 prosecution involved. But many times I will see things
20 where that's not currently a relevant consideration.
21 Q. Okay. How many children do you have, sir?
22 A. Three.
23 Q. All right. Do they all smoke?
24 A. Yes.
25 Q. Have you ever advised any of them they

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1 should stop smoking?

2 A. Yes.

3 Q. Have you advised all of them they should

4 stop smoking?

5 A. Each of them on various occasions, yes.

6 Q. Do you know if any of them have made an

7 attempt to stop smoking?

8 A. I just do not know how to answer that

9 question.

10 MR. SHEPPARD: Are we at a break point

11 here, if you mind?

12 (Recess)

13 BY MR. WESTBROOK:

14 Q. Okay. Doctor, in the last year have you

15 been deposed on any occasion?

16 A. Yes.

17 Q. Can you tell me approximately how many

18 times a year you sit for a deposition in one case or

19 another?

20 A. Well, on rare occasions I am deposed more

21 than once on the same case. The total number of

22 depositions I give is somewhere in the order of 10 to

23 20 per year.

24 Q. Did you say before, doctor, that most of

25 your involvement or a majority of your involvement in

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1 the litigation process is in criminal cases?
2 A. No. I think you misunderstood me.
3 Q. Okay. I must have. Could you break down,
4 between civil cases and criminal cases, what percentage
5 of your involvement is in each?
6 A. I think I have more cases that are civil
7 cases than criminal cases. You were asking about
8 groups of similar cases, and I said the only ones I had
9 that were substantially similar that I recognize that
10 are largely alike are in the criminal sector. But in
11 the civil sector there is a much wider scope, and the
12 cases are so variable, it's difficult to categorize.
13 And I thought that's what you were asking about, is
14 broad categories. And I apologize if I misunderstood
15 your question.
16 Q. No. I think your answer, I now understand
17 exactly what you were saying, doctor. In the criminal
18 side, do you appear on occasion for the state and
19 sometimes for the defense, although not in the same
20 case?
21 A. I don't recall any occasion for state where
22 I have appeared for both sides in the same case. I
23 have in the civil side, been engaged by all parties in
24 a complicated litigation.
25 Q. Let's start with the criminal cases.

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1 A. The criminal cases, I have not appeared for
2 state, to my recollection, in a number of years.
3 Q. Okay.
4 A. At one time all the cases were effectively
5 for state because I was a medical examiner.
6 Q. In your current consultation in criminal
7 cases for the criminal defendant, do any of those cases
8 involve drug questions?
9 A. Well, some probably do.
10 Q. Are you ever called upon to give an opinion
11 as to whether a person was under the influence of a
12 particular drug when he or she committed a crime?
13 A. Yes.
14 Q. Okay. How do you go about determining
15 whether a person is under the influence of a drug or
16 not through your pathological specialty?
17 A. The most frequent circumstance is alcohol.
18 Q. Okay.
19 A. And there is statutory determination of
20 impairment, in Florida. I don't know what it is like
21 in Mississippi.
22 Q. Those occasions, would you analyze the
23 results of a blood alcohol test for instance?
24 A. I might discuss the result. I don't know
25 what you mean by analyze.

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1 Q. You don't do the analysis yourself, I take
2 it?
3 A. No. I do not.
4 Q. But you may take the results of that
5 analysis and draw some opinions from it?
6 A. I may.
7 Q. Okay. Have you been involved in cases
8 involving heroin?
9 A. Probably, but I don't recall any
10 specifically.
11 Q. All right. Could you give me an estimate
12 within the last five years of how many of your criminal
13 involvement has been in cases involving alcohol?
14 A. I don't know.
15 Q. Would it be a large percentage?
16 A. Well, it would be appreciable, but I don't
17 think of it as large.
18 Q. Would it approach 50 percent?
19 A. I doubt it.
20 Q. Would it be as much as 25 percent of your
21 work on the criminal side?
22 A. I don't think so.
23 Q. Are there any other areas on the criminal
24 side where you have appreciable involvement with any
25 particular substance or disease?

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1 A. Any substance or disease. That sounds like
2 20 questions or something. Is it bigger than a bread
3 box or something?
4 Q. Let me break it down. Do you do much work
5 on AIDS cases?
6 A. Occasionally. I wouldn't say it's much
7 but --
8 Q. All right. Do you regard alcoholism as a
9 disease, sir?
10 A. That's an interesting question. I am not
11 sure I know the answer. Probably.
12 Q. Have you ever treated anyone for
13 alcoholism?
14 A. Not to my recollection. I can't imagine a
15 circumstance in which I would do that.
16 Q. On the civil side, sir, can you give me any
17 subjects that are the focus of an appreciable amount of
18 your time?
19 A. It seems to me that I probably spend more
20 time trying to read bad handwriting than almost any
21 other function I provide.
22 Q. All right. Is that doctor's handwriting?
23 A. I would be very cautious about drawing a
24 generalization, but I would say that doctors probably
25 have poorer handwriting than nurses and clerical

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1 personnel that record things by handwriting in medical
2 records.
3 Q. All right. Do you get involved in
4 malpractice cases?
5 A. Yes.
6 Q. Would malpractice cases form an appreciable
7 number of the cases you get involved in on the civil
8 side?
9 A. Yes.
10 Q. All right. And what types of malpractice
11 cases in the past five years have you been involved in
12 by category?
13 A. I am not sure how I would categorize them.
14 I think probably mistaken diagnosis is perhaps the most
15 common.
16 Q. All right. Have you been involved in cases
17 of mistaken diagnosis of lung cancer?
18 A. Yes.
19 Q. All right. Can you tell me something about
20 the details?
21 A. Well, that would require knowledge of all
22 of the cases, and I don't have that. All I can tell
23 you about is a few I can recall.
24 Q. Okay.
25 A. I have had several cases, a number of them,

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1 where a diagnosis of malignancy has been made; and the
2 correct diagnosis is not a malignancy at all. It's
3 something else, either a reparative process or
4 infection.
5 Q. All right. You said you have been involved
6 in cases where a lung cancer has been diagnosed and you
7 have determined that it wasn't a lung cancer?
8 A. Well, I think that I go beyond saying I
9 have determined is not a lung cancer. I think that it
10 is conceded it is not a lung cancer. It is definitely
11 not.
12 Q. All right. And as a result of the
13 misdiagnosis, what was it that brought the case in to
14 court, what cases in court?
15 A. Inappropriate treatment. I would not want
16 you to think that these all eventuate in something in
17 court. That's most unusual.
18 Q. What is the usual outcome of the matter?
19 A. The usual outcome of any case I see is that
20 I will tell people what I think about it and that's the
21 end of my involvement. And generally speaking, cases
22 don't go to court. If they do, I am not a part of
23 that.
24 Q. When you say when cases go to court, you
25 are not a part of that, do you not testify in court in

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1 medical malpractice cases?

2 A. Yes. But by no means as frequently as I

3 see cases.

4 Q. But when, you said, when the case goes to

5 court, you are not a part of that, do you have a policy

6 on not testifying in particular cases that you have

7 reviewed?

8 A. No.

9 Q. On what circumstances, then, would it be

10 that you have reviewed a case, given an opinion, then

11 the case goes to court and you are not a part of it?

12 A. Well, of course it may not go to court at

13 all. It may be simply dismissed. If it does go to

14 court, maybe I have given an opinion that they do not

15 find they wish to present for whatever reason; or in

16 the alternative, they find someone that is a better

17 person to appear. Also, when they go to court, it is

18 fairly common in my experience for them to settle. I

19 wish I had a check for every case I have seen that

20 settled on the courthouse steps. I have had the

21 occasion of going and sitting and waiting a whole day,

22 and absolutely nothing happens.

23 Q. Speaking of settlement, doctor, have you

24 read in the last week or two that one of the tobacco

25 companies has settled its litigation with the states?

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1 A. I read the headline, yes.
2 Q. All right. Did you read that that tobacco
3 company Liggett-Myers admitted that cigarette smoking
4 causes lung cancer?
5 MR. SHEPPARD: Object to the form of the
6 question. It is speculation.
7 A. I didn't read that.
8 Q. Okay. Did you read the article at all?
9 A. No. I read the headline.
10 Q. Doctor, how many cases of misdiagnosis of
11 lung cancer, when lung cancer wasn't there, have you
12 seen in your professional career?
13 A. I don't know.
14 Q. All right. Can you give me an
15 approximation?
16 A. Probably several dozen. I can think of
17 three that I have about right now.
18 Q. All right. Have you been involved in any
19 cases, doctor, where a physician failed to diagnose
20 lung cancer that was there?
21 A. I don't recall such a circumstance. That's
22 certainly possible.
23 Q. Doctor, do you agree that it is important
24 for physicians who are treating patients with cancer to
25 make every reasonable effort to determine the correct

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1 diagnosis, that is what type of cancer there is?
2 A. I think that's generally a correct
3 statement. There are circumstances in which it may not
4 be correct.
5 Q. When you say there are circumstances where
6 it may not be correct, you mean there are circumstances
7 where doctors shouldn't make every effort to determine
8 what disease the person actually has?
9 A. Yes.
10 Q. And what would those be?
11 A. Circumstances in which to make a
12 determination is not to the benefit of the individual.
13 Q. All right. Are you talking about
14 circumstances where the procedure to make the
15 determination could harm the individual?
16 A. That is certainly one example.
17 Q. All right. What other examples can you
18 think of?
19 A. Maybe a person that is effectively
20 untreatable and unsalvageable and it does not provide
21 benefit for him to have a greater definition of what
22 the problem is.
23 Q. All right. Are you aware of any cases
24 yourself where you made a determination in a patient
25 that had cancer not to attempt to determine where the

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1 cancer was located?

2 A. I am sorry. Please repeat the question.

3 Q. Yeah. Are you aware of any circumstances

4 that you have been involved in where you made a

5 determination not to try to figure out what type of

6 cancer a person had?

7 A. I don't recall such a circumstance. There

8 may be circumstances in which I have done an autopsy

9 for forensic purposes and the cause of death was

10 determined and whatever the type of cancer was was

11 immaterial. I don't remember any such circumstance

12 but. . .

13 Q. Uh-huh. Do different cancers respond to

14 different modes of therapy?

15 A. Yes.

16 Q. All right. Do different cancers respond to

17 different drugs?

18 A. That's generally a correct statement as far

19 as I know.

20 Q. Okay. For instance, if someone has a

21 bladder cancer, you might treat bladder cancer one way;

22 and if they have lung cancer, you might treat that a

23 different way. Correct?

24 A. Yes.

25 Q. You wouldn't give radiation therapy to the

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1 chest cavity to someone who has bladder cancer, would
2 you?
3 A. Not under general circumstances.
4 Q. So it is generally important to the
5 treating physician to know where the cancer is and what
6 type of cancer it is in order to determine which type
7 of treatment to prescribe, is that generally true?
8 A. It sounds like a correct proposition.
9 Q. Okay. Doctor, what are the types of lung
10 cancer by cell type?
11 A. Well, there are various categories. The
12 common ones are squamous cell and undifferentiated
13 small cell, rote cell. A category which is -- some
14 people use, others don't, is a large cell
15 undifferentiated. Adenocarcinoma. And then there are
16 some specific types that are less common:
17 bronchoalveolar carcinoma and a few adenomas of --
18 things of that sort.
19 And there is a mixture of all sorts of
20 other little things, including sarcomas of the lung and
21 things of that character, all of which are considerably
22 overshadowed by metastatic malignancy.
23 Q. Okay. Where is squamous cell carcinoma of
24 the lung usually found?
25 A. In connection with airways.

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1 Q. Okay. And how about adenocarcinoma?
2 A. It may be anywhere, but it commonly is
3 peripheral.
4 Q. What percentage of lung tumors in your
5 experience are primary to the lung?
6 A. Are you talking about per case or the
7 number of tumors? For example, I have seen metastases
8 where there are hundreds of them.
9 Q. Let's back up so we see if we can
10 understand each other. Have you seen statistics
11 indicating that in individuals a given number or a
12 given percentage of the tumors that are located in the
13 lungs are primary and a given percentage are
14 metastatic?
15 A. I think I have seen numbers like that. I
16 am not sure they have any real relevance. You take
17 them case by case and make a determination.
18 Q. Why would you say the numbers don't have
19 any relevance?
20 A. Because when you get to a case, it doesn't
21 matter what the percentage is. If it's a reasonable
22 likelihood, you have to consider that likelihood.
23 Q. Would you treat a metastatic lung tumor
24 differently from a primary lung tumor?
25 A. It depends upon what the tumors are and the

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1 circumstances. But that sounds like a generally
2 correct statement.
3 Q. And what differences in treatment modality
4 do you use for primary tumor versus a metastatic tumor
5 in the lung?
6 MR. SHEPPARD: Well, I do object to the
7 form of that because he has indicated he is not a
8 treating doctor who treats cancer patients, and now you
9 are asking him how he treats them, so I think it's
10 confusing.
11 MR. WESTBROOK: Counselor.
12 MR. SHEPPARD: I am sorry. I just simply
13 say I object. It's confusing, counsel.
14 MR. WESTBROOK: Okay. Thank you, counsel.
15 THE WITNESS: What was the question?
16 MR. WESTBROOK: Would you read the doctor
17 that question.
18 (The question was read by the reporter.)
19 A. Okay. Well, I don't use any of them
20 so. . .
21 Q. Are you aware of the differences in
22 treatment that doctors who treat cancer use for
23 metastatic tumor versus a primary tumor of the lung?
24 A. Only a very general way.
25 Q. All right. Generally tell me what the

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1 differences in treatment are.

2 A. Well, surgery is used for both; radiation

3 may be used for both; and chemotherapy may be used for

4 both. And I think those are the three arms. The

5 details of course are considerably different or may be

6 considerably different, and I just don't do that.

7 Q. Okay. As a pathologist, doctor, when you

8 examine a tumor, a section of a tumor on a slide under

9 a microscope, can you tell whether that tumor from the

10 lung is a primary or metastatic tumor?

11 A. Sometimes no. Other times, you can make a

12 reasonable statement of probability.

13 Q. All right. And on what factors do you base

14 the reasonable statement of probability in those cases

15 where you can do so?

16 A. Simply looking at it with a microscope, or

17 do you have other information?

18 Q. Well, let's start out with the microscope.

19 Then tell me what additional information you would need

20 to have.

21 A. Well, with a microscope, you may or may not

22 be able to tell.

23 Q. Okay. What else would you need to do?

24 A. It would be nice to have all of the

25 available information. For example, if you know that

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1 there is a multiplicity of lesions in the lung and that
2 there is some primary somewhere to serve as a source,
3 that would certainly make metastasis a much more likely
4 thing, irrespective of what it looks like.
5 Q. If you know there is a primary somewhere
6 else, aren't you 90 percent of the way there to knowing
7 that the lung tumor is a metastasis?
8 A. I don't know whether you are 90 percent
9 there or not. It certainly is one of the things that I
10 would consider.
11 Q. Okay. And what is the protocol that a
12 physician goes through when a lung tumor has been
13 detected and a person is still alive, to attempt to
14 determine whether that tumor is primary or not?
15 A. What is the protocol?
16 Q. Yes, sir.
17 A. I think it varies with individuals.
18 Moreover, that's not something I do. I don't treat
19 people.
20 Q. Do you have any familiarity with the steps
21 that a physician goes through to determine whether a
22 lung tumor is primary or a metastasis?
23 A. Well, I presume they have to collect the
24 information that is available in that case and process
25 it and make a judgment from it. But that's not

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1 something I do.

2 Q. All right. Do you know of any of the

3 specifics? You say collect the information to make a

4 judgment. That's what doctors do in every case,

5 correct?

6 A. That's correct.

7 Q. All right. With specificity, doctor?

8 A. Maybe you could say on the basis of

9 statistics what something is. You wouldn't need to

10 collect that information.

11 Q. All right. Do you know with specificity

12 any of the procedures that an oncologist or treating

13 physician goes through when he or she determines there

14 is a tumor in the lung and wants to determine if that's

15 a primary tumor or metastasis; do you know what the

16 next step is?

17 A. Do I know what the oncologist considers the

18 next step? No, I don't know what the oncologist

19 considers the next step.

20 Q. Do you know what the treating physician

21 would consider the next step?

22 A. I have no idea.

23 Q. Are there standard protocols that

24 oncologists follow in order to eliminate the tumor as a

25 metastasis and determine it is a primary?

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1 A. I don't know.
2 Q. Have you ever yourself, doctor, been called
3 upon to determine in a patient who is living whether a
4 lung tumor was a primary tumor or metastasis?
5 A. I am sure I have. I don't remember the
6 occasion, but I am sure I have done that sort of thing.
7 Q. You don't remember any specific instance?
8 A. No.
9 Q. Okay. Doctor, what percentage of your
10 professional practice today is devoted to consultation
11 with attorneys in matters that are either in litigation
12 or may come into litigation?
13 A. Well, I would say that's most of what I
14 do. But I don't want you misled. I have a
15 consultation practice, and I deal with attorneys,
16 paralegals, adjusters, insurance companies, risk
17 managers for large companies and hospital chains,
18 nursing homes, public defenders, a lot of public
19 agencies, county, city, state, federal. So it's not
20 just all attorneys.
21 Q. But most of what you do involves cases that
22 are either in litigation or may come into litigation in
23 some way?
24 A. There is some potential for that, I would
25 say. There are some where it is strictly matter of

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1 curiosity. And there are rare patients or indeed
2 families of patients who will hire me for no other
3 reason than to have their curiosity satisfied. And I
4 don't have any reasonable expectation that that would
5 ever be litigated.
6 Q. Would you say that's a small part of your
7 practice?
8 A. Yes.
9 Q. All right. And what is your hourly rate
10 for consultation?
11 A. $200 an hour.
12 Q. Okay. Does that rate change at all
13 depending on who is consulting with you?
14 A. No. There are people that have indicated
15 that that's not within their budgetary constraints.
16 And, for example, there are a couple of public
17 defenders that pay $150. And I generally try not to do
18 a lot of work for that because it is less money. On
19 the other hand, I do do occasional ones for them
20 because I feel it serves a public purpose.
21 There is one judge with whom I am familiar
22 with that has decided that all experts are paid $133 an
23 hour irrespective of who they are, what they are. And
24 that means that some come and get more than they bill
25 and some come and get less than they bill. And it is a

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1 bed of Procrustes, and they just cut every bill to
2 measure and. . . But generally speaking, I charge $200
3 an hour.
4 Q. I take it you don't do much work before the
5 $133-an-hour judge?
6 A. I try not to, but there is a defense
7 attorney that occasionally has things in that venue
8 that is very persuasive and so I occasionally do things
9 there.
10 Q. All right. And, doctor, is $200 an hour
11 the rate that you are billing the tobacco company
12 attorneys?
13 A. Yes.
14 Q. All right. Doctor, have you consulted
15 directly with any of the tobacco companies on matters
16 of tobacco and health?
17 A. No. Not to my recollection. I can't
18 imagine how that would happen.
19 Q. Do you know how the tobacco company
20 attorneys came to locate Dr. Willey and contact him?
21 A. I am not sure. I know I was called by
22 several attorneys in the area and asked if I would be
23 willing to examine cases from time to time.
24 Q. All right. And by examining cases from
25 time to time, are you talking about individual cases of

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1 individuals, people who claim that they were made sick
2 by cigarettes?
3 A. I have no idea what the claims were. It's
4 just a matter of looking at slides.
5 Q. All right. And were the slides, to your
6 understanding, slides that were generated in connection
7 with the tobacco controversy of some sort?
8 MR. SHEPPARD: I do -- I do object to the
9 form as to the vagueness of the term "generated".
10 A. I don't know.
11 Q. All right. Who was the first attorney who
12 identified himself or herself as associated with a
13 tobacco company who contacted you?
14 A. I can't remember her name. It is a female
15 attorney in the Williams, Brasfield, Wertz firm. And
16 at that time I was busy and I said no.
17 And then subsequently Suzanne Elinger, I
18 believe, called and asked if I would look at some
19 slides and --
20 Q. And did you say yes?
21 A. I said yes, but I didn't want to look at
22 very many of them because I had plenty to do.
23 Q. All right. Now, where is the Williams firm
24 located?
25 A. I believe it is on 1st Avenue North.

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Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 Q. All right. In St. Petersburg?
2 A. Yes.
3 Q. Who was the attorney from that firm?
4 A. I told you I was trying to remember her
5 name. And I don't recall her name. She has left now,
6 by the way.
7 Q. And when was that first contact with the
8 Williams firm approximately?
9 A. That was before this year. I don't know
10 when it was exactly.
11 Q. Do you think it may have been two years
12 ago?
13 A. Well, I didn't make any note of it, and I
14 don't recall it with precision. I don't even remember
15 her. My best belief would be that it is somewhat over
16 a year ago, but I do not know that that's correct.
17 Q. All right. Then your next contact came
18 from Suzanne Elinger?
19 A. Right.
20 Q. Where does Ms. Elinger practice?
21 A. In Tampa.
22 Q. Okay. What is her firm, if you know?
23 A. I know, but I can't recall right now.
24 Q. All right. And do you --
25 A. Look her up. It's much simpler.

http://legacy.library.ucsf.edu/tid/nhq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 Q. Well, not if you remembered, it wouldn't be
2 simpler. But if you don't remember, that's the next
3 best thing.
4 A. I don't.
5 Q. And so Ms. Elinger asked you to look at
6 some slides, and did you understand that the slides
7 were from an individual who allegedly had
8 tobacco-related disease?
9 A. Well, I understood they were from an
10 individual, and I understood that that was an
11 allegation, yeah.
12 Q. All right. And did you look at the slides?
13 A. Well, I have looked at a couple sets of
14 slides on different occasions.
15 Q. Were the sets of slides from different
16 people?
17 A. That is my best belief, yes.
18 Q. Okay. What was the purpose of your looking
19 at the slides; what were you trying to determine?
20 A. Find out what was there.
21 Q. All right. And what in particular were you
22 looking for?
23 A. Nothing. They just gave me the slides to
24 look at. They didn't give me any information to speak
25 of.

http://legacy.library.ucsf.edu/tid/nhq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 Q. So the attorneys called you up, said, we
2 are going to send you some slides, look at them; that's
3 basically what happened?
4 A. Well, in general substance, yes. The
5 specific details, that's not correct. But the general
6 statement of what happened is correct.
7 Q. You say detail is incorrect. Did the
8 attorneys want you to look and see if the slides showed
9 a tumor?
10 A. Well, they didn't tell me what they wanted
11 me to do. They just wanted me to look at the slides
12 and tell them what the slides had. They didn't give me
13 a statement of what they expected me to find. And they
14 didn't ship them to me. They were brought. And I
15 looked at them and discussed them.
16 Q. Okay. So did someone from the law firm
17 come to your office and bring you the slides?
18 A. I beg your pardon?
19 Q. Did someone from the law firm come to your
20 office and bring you the slides?
21 A. Not that law firm. Other law firms.
22 Q. Okay. Let me see if I understand this.
23 Ms. Elinger contacted you and asked you if you would be
24 willing to look at some slides; and you said within the
25 limits of your time, yes. Am I right so far?

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Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 A. Yes.

2 Q. Then other law firms then brought you

3 slides to look at in connection with tobacco cases; is

4 that right?

5 A. On occasion, yes.

6 Q. On occasion. And did you understand that

7 those slides were in connection with individual tobacco

8 and health claims?

9 A. Yes.

10 Q. Okay. And then individuals from other law

11 firms brought you down these slides. Do you know who

12 the individuals were from the other law firms?

13 A. I don't remember them.

14 Q. All right. Were they attorneys?

15 A. Yes.

16 Q. All right. Do you know what firms they

17 came from?

18 A. No.

19 Q. Did you know that they were representing

20 tobacco companies?

21 A. Yes.

22 Q. Do you know which companies?

23 A. No.

24 Q. Did you render any written opinions

25 concerning the slides you looked at?

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Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 A. No.

2 Q. Did you give oral opinions to the attorneys

3 concerning the slides?

4 A. Yes.

5 Q. Okay. Subsequent to you giving opinions to

6 the attorneys concerning those slides, were you

7 retained to consult on those cases?

8 A. No.

9 Q. All right. Were you ever deposed in those

10 cases?

11 A. No.

12 Q. All right. Did you inform those attorneys

13 that you found lung tumors on the slides?

14 A. No.

15 Q. All right. What did you inform them as

16 best as you can recall?

17 A. Well, one case I remember specifically,

18 there was no tumor whatsoever.

19 Q. Were you told that these slides were lung

20 tissue?

21 A. You can tell by looking at them. You don't

22 have to be told.

23 Q. All right. And could you tell by looking

24 at them that they were lung tissue?

25 A. Sure.

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Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 Q. Okay. And on one set of slides, you saw no
2 tumor?
3 A. That's correct.
4 Q. All right. On other sets of slides, did
5 you find tumors?
6 A. Not lung tumors.
7 Q. All right. What types of tumors did you
8 find?
9 A. I think the other case that I recall was a
10 cancer of colon.
11 Q. Okay. And did you find colon tumors in
12 that case?
13 A. Just one.
14 Q. Was it primary or metastasis?
15 A. It was primary.
16 Q. Okay. How did you determine that?
17 A. Its appearance.
18 Q. All right. And how do you distinguish a
19 primary colon cancer from a metastatic colon cancer?
20 A. You can't do it with complete assurance.
21 But generally speaking, lung cancers have a
22 characteristic appearance. They appear to arise from
23 altered surface epithelium of the colon.
24 Q. All right. And how would a metastatic
25 colon tumor appear differently?

http://legacy.library.ucsf.edu/tid/nhq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 A. It does not appear to arise from altered
2 colon lining tissue.
3 Q. Where does it appear to arise from?
4 A. It appears to arise centrally and extend
5 laterally and push aside or infiltrate otherwise nearly
6 normal tissue.
7 Q. All right. So we have one case where you
8 found no tumor, and that was in lung tissue?
9 A. Yes.
10 Q. We have one where you found you saw a tumor
11 in colon tissue?
12 A. Yes.
13 Q. Can you recall any other cases that you
14 looked at slides for the tobacco companies?
15 A. I don't recall any others.
16 Q. All right. And when, doctor, in time
17 approximately did you do this examination of the
18 slides?
19 A. Last year.
20 Q. Doctor, what was your next contact with
21 attorneys representing the tobacco company?
22 A. I don't recall specifically, but you have
23 copies of the correspondence.
24 Q. Doctor, I didn't see any correspondence
25 where you were contacted by the attorneys for the

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Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 tobacco companies asking if you would consult on this
2 case. How did that come about?
3 A. I think I was called by telephone. And
4 they visited.
5 Q. And who called you?
6 A. I don't remember for certain.
7 Q. Where were they from?
8 A. The Shook, Hardy firm.
9 Q. Okay. And was that contact within the past
10 year?
11 A. Yes.
12 Q. All right.
13 A. I believe so.
14 Q. All right. And then lawyers from the
15 Shook, Hardy firm visited you?
16 A. Yes.
17 Q. All right. Who were the lawyers who
18 visited you?
19 A. Among them, Mr. Sheppard. And
20 Ms. Lindgren-Bron.
21 Q. And prior to this telephone contact, had
22 you ever heard of the Shook, Hardy law firm before?
23 A. No.
24 Q. Did the lawyers tell you that you had been
25 recommended by some other lawyers?

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Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 A. I don't think so.
2 Q. Did they tell you how they got your name?
3 A. I presume they got it from Ms. Elinger, but
4 I don't know that. They didn't tell me.
5 Q. Approximately when did you start consulting
6 with the Shook, Hardy firm, sir?
7 A. Well, whenever my first statement shows we
8 met and did that. I have got it here somewhere.
9 Q. Okay. That was my next point. The
10 response to the document request from Shook, Hardy firm
11 does indicate that the billing records would be
12 provided at a later time. You have those with you,
13 sir?
14 A. Yes.
15 (The witness handing documents to
16 Mr. Westbrook.)
17 MR. WESTBROOK: Thank you. Off the record.
18 (Off the record discussion)
19 BY MR. WESTBROOK:
20 Q. Doctor, do you know for how long the Shook,
21 Hardy firm has represented tobacco companies in
22 litigation?
23 A. No.
24 Q. Have you ever been to the Shook, Hardy
25 offices in Kansas City?

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Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 A. No.
2 Q. You mentioned two lawyers from the Shook,
3 Hardy firm with whom you have met. Have you met any
4 other lawyers from the Shook, Hardy firm?
5 A. Yes, but I can't remember his name. It was
6 another person. Perhaps the correspondence will help
7 you.
8 Q. Or you.
9 A. No. Because you can -- yeah. That's good.
10 Q. Does the correspondence help you to
11 remember his name, doctor?
12 A. No. I still don't remember his name. The
13 correspondence speaks for itself, though.
14 Q. And having looked at the correspondence,
15 doctor, do you recall corresponding with any other
16 Shook, Hardy attorneys?
17 A. I sent a bill. I don't know what other
18 correspondence. I think that's been supplied, though,
19 too.
20 Q. Yes. And who did you send the bill to?
21 A. Keith T. Borman, B-o-r-m-a-n, esquire.
22 Q. Okay.
23 A. You want that back?
24 Q. Yes. Doctor, on November 7th, 1996, the
25 correspondence indicates you sent Mr. Borman a bill for

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1 some time beginning on the 1st of October, 1996,
2 reference to a telephone call. To the best of your
3 recollection is that the first contact that you had
4 with the Shook, Hardy firm?
5 A. I don't recall.
6 Q. Okay. Is the November 7th, 1996 bill the
7 first bill that you sent to the Shook, Hardy firm?
8 A. I don't know that either. That appears to
9 be correct.
10 Q. Okay. And, doctor, your billing records
11 indicate that on October 15th, 1996, you had a
12 conference in the office for two hours?
13 A. Yes.
14 Q. Would that be the meeting with the Shook,
15 Hardy lawyers that you recalled earlier?
16 A. I presume.
17 Q. All right. Did the lawyers bring you
18 anything to read when they came to you, to see you?
19 A. Not that I recall.
20 Q. All right. Did they send you thereafter
21 any medical or scientific articles to read?
22 A. Yes.
23 MR. WESTBROOK: Let's mark next the
24 November 7th, 1996 letter from Dr. Willey to Keith
25 Borman.

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1 (Exhibit No. 5 was marked for
2 identification.)
3 A. Do you want it back?
4 Q. Thank you, sir.
5 A. Uh-huh.
6 Q. Doctor, counsel has produced to us a number
7 of articles from medical and scientific literature.
8 And I'd like to ask you, are those the articles to the
9 best of your knowledge that were sent to you by the
10 Shook, Hardy firm?
11 A. Yes. I compared them with my file.
12 Q. And as far as you know, there are no
13 articles missing from what you were provided from the
14 group that we were provided?
15 A. Well, I don't know what you were provided.
16 All I can say is I compared the set that I currently
17 have with my file, and I believe I identified all the
18 counterpart articles. And if you want to take this and
19 compare it with what you were provided, --
20 Q. All right.
21 A. -- I would certainly be agreeable.
22 Q. All right. Let me show you Exhibit 3,
23 doctor, which is the correspondence from Shook, Hardy
24 to me, sending me articles. And under paragraph one,
25 the articles are listed. And would you compare what I

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1 was sent to what you have and confirm, if you will,
2 that we were sent all the articles that Shook, Hardy
3 provided you?
4 (Recess)
5 BY MR. WESTBROOK:
6 Q. Doctor, have you had a chance to compare
7 the list of articles that was sent to us with the
8 list -- with the actual articles that you got from the
9 Shook, Hardy firm?
10 A. Yes.
11 Q. And are they the same?
12 A. They appear to be the same.
13 Q. Okay. Now, and, doctor, did you make
14 notations on the articles when you read them after the
15 Shook, Hardy lawyers sent them to you?
16 A. No.
17 Q. All right. Did you keep some separate
18 notes on the articles, sir, when you read them?
19 A. No.
20 Q. Did you annotate the articles in any way?
21 A. I am sure I probably made some check marks
22 or red lines or something like that, but other than
23 that, no.
24 Q. Are you holding your file copy of the
25 articles, sir?

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1 A. No.

2 Q. All right. Is there a different set of the

3 articles that you have back in your office?

4 A. There is an additional set that I have in

5 my office.

6 Q. All right. And did you write anything on

7 the set of articles that you have in your office at

8 all?

9 A. That's been asked and answered. The answer

10 was no, I didn't write anything on there. I may have

11 made some marks and some underlining, but I did not

12 write anything on there to the best of my recollection.

13 Q. All right. And what did you mark on or

14 underline in the articles by general category?

15 A. The only thing I can recall is that I mark

16 things that at the time strike me as of interest. What

17 they were, I don't know.

18 Q. Okay. All right.

19 A. Do you want Exhibit 3 back?

20 Q. Doctor, subsequent to your writing your

21 November 7th, 1996 letter to the Shook, Hardy firm,

22 where you say that, quote, "I have read the articles

23 you sent. Thank you", unquote, did you receive to your

24 knowledge any additional articles to review?

25 A. No.

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1 Q. And did you yourself go to any source for
2 medical or scientific articles and do any independent
3 review in the medical literature?
4 A. No. Not to my recollection. You are aware
5 I did supply one other copy, one other article myself,
6 are you not?
7 Q. Did you send a copy of this article to the
8 defense counsel?
9 A. Yeah, I gave it to them. I don't know how
10 they got it, but I originated it for them.
11 Q. All right. So with the exception of this
12 article which is entitled "The Epidemiologic Necropsy",
13 unquote, all the other articles were received by you
14 from the Shook, Hardy firm?
15 A. That's my best recollection. That's
16 correct.
17 Q. All right. And where did you get the
18 article that you supplied to defense counsel?
19 A. From my file.
20 Q. Okay. And what type of file do you keep,
21 sir, from which you got this article?
22 A. I keep a file of articles that I have
23 removed from journals to which I subscribe and articles
24 that I have collected over the years.
25 Q. All right. Did you make a comprehensive

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1 review of this file of articles to see if there were
2 any other articles in there that you thought were
3 relevant to the issues on which you were asked to
4 consult?
5 A. No.
6 Q. All right. How did you come upon this one
7 article?
8 A. By happenstance.
9 Q. Were you looking through your files for
10 something else and you just came across this article?
11 A. I was looking for another article, if I
12 recall correctly, by McFarlane and found that one.
13 Q. Was the article you were looking for by
14 McFarlane an article that you were looking for in
15 connection with a different consultation?
16 A. No.
17 Q. Was it in connection with this
18 consultation?
19 A. Yes.
20 Q. Okay. And what article by McFarlane were
21 you looking for?
22 A. I don't know, but it is one fairly
23 proximate in date to that.
24 Q. Okay. Do you know Dr. McFarlane?
25 A. No.

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1 Q. Who is the first author on this paper? Do
2 you know Dr. Feinstein?
3 A. No.
4 Q. Do you know Carolyn Wells?
5 A. No.
6 Q. Do you know Charles Chan?
7 A. No.
8 Q. Doctor, let me ask you to take a look at
9 the last page of the article that you have supplied to
10 me.
11 A. Yes.
12 Q. Does it appear that the article continues?
13 A. Yes.
14 Q. All right. Did you have in your files just
15 a portion of the article?
16 A. I don't recall that.
17 Q. Okay. Do you normally keep the complete
18 articles in your file?
19 A. Yes.
20 Q. All right. Doctor, on your November 7th
21 bill to the Shook, Hardy firm, you have time for
22 paramedical nursing time that you billed the Shook,
23 Hardy firm?
24 A. Yes.
25 Q. Who was that time for?

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1 A. Valerie J. Ginn, G-i-n-n.
2 Q. And what did she do?
3 A. I have no recollection. How much time was
4 it?
5 Q. Three-tenths of an hour.
6 A. I haven't the faintest idea. Whatever it
7 was, it's cheaper having her do it than me,
8 considerably.
9 Q. Does she type?
10 A. Yes. Types much better than I do, if
11 that's what you mean.
12 Q. Does she type your letters?
13 A. Generally not.
14 Q. You have a separate bill for transcription
15 as well?
16 A. Right.
17 Q. Okay.
18 A. I find it is considerably less expensive
19 for my clientele to itemize things like that because
20 there are people that produce very heavy transcription
21 requirements, and it is not fair to split that with
22 other people that have much less. So I try to break
23 that out.
24 Q. I am curious. You met with the attorneys
25 on this bill, and then you got some articles and you

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1 read them. And I am curious as to what a paramedical
2 nurse was doing on this project.
3 A. I have no recollection, as I told you.
4 Whatever it was is probably some form of clerical
5 function I could reasonably assign.
6 Q. To the best of your recollection, you
7 didn't have anyone type up any notes on these articles,
8 did you?
9 A. I am quite certain I didn't.
10 Q. Okay. Have you prepared, other than your
11 expert disclosure statement, --
12 And we will get to that.
13 -- have you prepared any opinion letters
14 or opinion memos for this attorney general's case?
15 A. No. I think that you got all the
16 correspondence, everything I have prepared. Unless you
17 construe one of those as a report or an opinion or
18 something, which I do not do.
19 Q. Okay.
20 A. The answer is no.
21 Q. Okay. Are you aware, doctor, whether you
22 have been retained by the tobacco companies to testify
23 in any other attorney general's suit?
24 A. Not --
25 MR. SHEPPARD: Wait. I do object to that

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1 as attorney-client privilege, if he is going to ask us
2 to elaborate or not. He has been asked to consult
3 only. As if he has been asked to consult as a
4 consultant or not --
5 MR. WESTBROOK: Maybe we can avoid the
6 problem.
7 MR. SHEPPARD: Sure. Go ahead.
8 MR. WESTBROOK: Maybe not have one.
9 MR. SHEPPARD: Go ahead.
10 BY MR. WESTBROOK:
11 Q. Doctor, are you aware whether you are being
12 listed as an expert by the tobacco companies in any
13 other attorney general's action?
14 A. I am not aware.
15 Q. All right. Are you aware that the State of
16 Florida Attorney General has sued the tobacco
17 companies?
18 A. Yes. That's been in the newspapers.
19 Q. All right. And if you are asked, doctor,
20 do you intend to testify as an expert for the tobacco
21 companies against the State of Florida?
22 A. Well, that's a question that embodies bias
23 and suggests that my testimony is all against. Most of
24 my testimony, as far as I know, is mere facts. And
25 it's neither for or against. It's just a matter of

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1 statement of fact.

2 Q. Okay. But you understand, doctor, that you

3 are being offered by the tobacco companies because of

4 their belief that you are saying something favorable to

5 their position in litigation, don't you? That's no

6 surprise?

7 A. Well, I don't think any person selects any

8 witness that he doesn't think has something favorable.

9 Q. Okay.

10 A. Is that -- is that responsive to your

11 question? I don't know.

12 Q. It is responsive to this question, but now

13 I will go back to my previous question. If you were

14 asked to testify by the tobacco companies in the

15 lawsuit in which they are defending against the claims

16 of the Attorney General of Florida, do you intend to

17 testify in that case on behalf of the tobacco

18 companies?

19 A. Well, assuming all other things are

20 acceptable, I'm alive and well and I have time and what

21 I have to say is potentially useful in some way to the

22 parties, yes.

23 Q. Now, when you say potentially useful in

24 some way to the parties, the party who is retaining you

25 is the tobacco industry, right?

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1 A. Yes, but I fully expect that any testimony
2 I offer will be used by both sides. That's invariably
3 the case.
4 Q. How do you expect the Attorney General of
5 Mississippi in this case to use your testimony, sir?
6 A. I have no idea. I am not the attorney
7 general.
8 Q. You said you fully expected that the both
9 sides would use your testimony.
10 A. Absolutely.
11 Q. On what do you base that with respect to
12 this case?
13 A. I have no knowledge what they will do.
14 That just seems like a reasonable expectation, that
15 both parties use whatever testimony is there in
16 whatever way they see fit.
17 Q. Do you have any specific reason to say that
18 in this case?
19 A. In this case? No. It hasn't happened
20 yet. We will wait and see.
21 Q. Doctor, do you know who the tobacco
22 companies are?
23 A. I do not have any sort of knowledge about
24 the structure of tobacco companies, no.
25 Q. All right. And I take it, then, you don't

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1 know who the defendants are in this case?
2 A. Not specifically, no.
3 Q. Okay.
4 A. It doesn't matter. Facts are facts.
5 Q. Have you reviewed any of the tobacco
6 companies' internal scientific testing documents or
7 reports in preparation for your testimony?
8 A. No.
9 Q. Are you a member of the American Medical
10 Association?
11 A. Yes.
12 Q. All right. Did you read the Journal of the
13 American Medical Association volume about a year or so
14 ago which contained reports on the tobacco company's
15 internal papers?
16 A. Probably.
17 Q. Did you read the editorial on behalf of the
18 American Medical Association where the AMA urged
19 physicians to cooperate in the efforts of the states
20 against the tobacco industry?
21 A. I don't remember that specifically.
22 Q. Assuming that occurred, doctor, that is
23 something that you are not doing, isn't it?
24 A. That doesn't really sound like a proper
25 request to me in my judgment, to make up their minds

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1 what all of the facts should be and how they should be
2 interpreted and the outcome. It seems to me like that
3 completely overlooks the trier of fact that is supposed
4 to balance things.
5 Q. Assume that the American Medical
6 Association has stated that, because cigarettes cause
7 disease, a lot of young people are smoking, that
8 physicians in order to help the health and welfare of
9 their patients generally should cooperate in efforts to
10 prevent youth from smoking and from cigarette smoking
11 from continuing in this country. Let's assume that's
12 the substance of what the AMA has said, along with some
13 other things, and then advised physicians that they
14 should cooperate to the extent possible with efforts
15 against the tobacco companies. Do you feel that that's
16 an improper request to the medical profession?
17 A. I think it's a political statement that is
18 not proper to suggest that they should shape their
19 opinions, beliefs and facts and things of that sort in
20 a manner such as to effect the outcome.
21 Q. Okay.
22 A. I am surprised they don't think that.
23 Q. Have you ever been an officer of the
24 American Medical Association?
25 A. No.

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1 Q. You have never headed any committee of the
2 American Medical Association?
3 A. No.
4 Q. Okay. Have you ever been involved with any
5 medical association or medical society committee that
6 looked into the issue of the health effects of smoking?
7 A. No.
8 Q. Have you ever been asked by the State of
9 Florida or any of its agencies to consult on issues
10 involving tobacco and smoking -- excuse me, tobacco,
11 smoking, and health?
12 A. And health?
13 Q. Yes.
14 A. All three together, no.
15 Q. Okay. Have you ever consulted with any
16 agency of the State of Florida on the issue of
17 cigarette smoking?
18 A. Not to my recollection.
19 Q. All right. Have you ever consulted with
20 any agency of the State of Florida on any tobacco
21 issue?
22 A. I don't recall any.
23 Q. Doctor, are you aware of something called
24 the surgeon general's report on tobacco and health?
25 A. I don't know whether there is more than one

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Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 report, but there is a report of many decades ago. I
2 once had it on my shelf. I think it has probably
3 fallen apart and been discarded.
4 Q. Did you read it, sir?
5 A. Yes.
6 Q. Did you agree with it?
7 A. I don't have total recollection of all of
8 it. If you want to inquire specifically about the
9 language, I guess you are free to do that. I don't
10 remember it.
11 Q. All right. Assume for me that in a general
12 way the surgeon general said that cigarette smoking was
13 harmful to health. Would you agree with that
14 statement?
15 MR. SHEPPARD: Let me object to the form of
16 the question as incorporating a lengthy, extensive
17 document that he has not reviewed, there is no
18 testimony, in recent years.
19 A. Please read the question back.
20 (The question was read by the reporter.)
21 A. Well, that leaves out a lot of details.
22 And I do not think that smoking is a good thing for
23 people to do, and it may be harmful to their health.
24 Q. Have you ever been asked by the Surgeon
25 General of the United States to sit on any of the

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1 various committees that make up the groups that write
2 the reports called the Surgeon General's report?
3 A. No.
4 MR. WESTBROOK: Let's mark next an excerpt
5 from the 1969 supplement to the 1967 document, "The
6 Health Consequences of Smoking".
7 (Exhibit No. 6 was marked for
8 identification.)
9 Q. Doctor, if you would take that document in
10 front of you there, "The Health Consequences of
11 Smoking". And I want to ask you for a minute about
12 some of the people who are involved in preparing of
13 this report on behalf of the government. On page Roman
14 numeral V. Are you with me, sir?
15 A. Yes.
16 Q. Okay. There is an acknowledgment of the
17 people who contributed, with the notation that special
18 thanks are due to those people, correct?
19 A. Let me read it.
20 Q. Yes, sir.
21 A. And your question was, does it read,
22 special thanks are due?
23 Q. And identify a number of physicians an
24 scientists who are being thanked for assistance in
25 preparing this report?

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1 A. Yes, you read it correctly as far as I am
2 aware.
3 Q. All right. Would you scan the list of
4 names, sir, and let me know if you have worked with any
5 of these individuals?
6 A. It is an incomplete list. It begins at
7 Roman five and extends to Roman six, and the next page
8 is Roman nine.
9 Q. You are right, sir. Page seven is --
10 A. And it terminates with "Peterson".
11 Q. Right. Do you see over in the right-hand
12 side that a portion of page seven with the last names
13 has been copied?
14 A. Oh, yeah, that's correct.
15 Q. Okay.
16 A. It is truncated but --
17 Q. But you are correct, that that page is --
18 and we can supply that page in this copy. It is not on
19 my copy either.
20 A. And your question was?
21 Q. Reviewing page five, which is complete,
22 page six, which is complete, --
23 A. Yeah.
24 Q. -- and the last names, at least, on page
25 seven, which end with the W's, correct?

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1 A. Well, it begins with P.
2 Q. And ends with?
3 A. Ends with Wynder, W-y-n-d-e-r.
4 Q. All right. Pretty close to the end of the
5 alphabet?
6 A. Fairly close, yeah.
7 Q. All right. Do you recognize the names as
8 any of the people you have worked with?
9 A. No.
10 Q. You don't recognize any of the names as
11 doctors or scientists with whom you have ever worked;
12 is that right?
13 A. Yes. That's what I did convey by the
14 answer no.
15 Q. Would you agree that the contributors to
16 this report, sir, include, for instance, Dr. Endicott,
17 who is the director of the National Cancer Institute,
18 National Institute of Health?
19 A. Well, he was at that time, I presume. This
20 is 1967, correct?
21 Q. 1969, I think?
22 A. 1969. Okay. The handwriting is
23 indistinct. Prior to whenever this was on here. It is
24 printed 1969 supplement. Sometime about that time or
25 prior, I would assume that that's correct, that he was

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1 a director of the National Cancer Institute.

2 Q. And is so listed there?

3 A. Appears to be.

4 Q. And the director of the National Cancer

5 Institute would have significant experience in matters

6 involving cancer, would he not?

7 MR. SHEPPARD: Object, form, speculation.

8 A. I don't know.

9 Q. All right. You don't know whether he would

10 have experience in cancer or not, becoming the director

11 of the National Cancer Institute?

12 MR. SHEPPARD: Objection, speculation.

13 A. I simply do not know anything about

14 Dr. Endicott.

15 Q. Do you know anything about the Johns

16 Hopkins School of Hygiene and Public Health?

17 A. I am aware of the Johns Hopkins

18 University. I am not specifically familiar with the

19 School of Hygiene and Public Health.

20 Q. All right. There is a Dr. Dietrich

21 Hoffmann listed from the Sloan Kettering Institute for

22 Cancer Research. In your view is that one of the

23 leading cancer research institutes in this country?

24 A. I suppose there are different indicia for

25 leading, probably a number of publications and things

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1 of that character, how much funding they have. That's
2 my best belief, that they produce a significant number
3 of publications, and they have substantial funds they
4 devote to that.
5 Q. Okay. And am I correct that you have not
6 published any papers regarding tobacco, smoking, and
7 cancer?
8 A. That is certainly my best belief.
9 Q. Doctor, I want to ask you about a portion
10 of the summary of the report which begins on page three
11 and on page four, where the panel is discussing smoking
12 and cancer, at the very top of the page there. The
13 sentence under smoking and cancer begins, quote,
14 "Additional evidence substantiates the previous
15 findings" --
16 A. Okay. You are ahead of me. I have got
17 page three. It is a summary and --
18 Q. Go to page four, sir.
19 A. Oh. Okay. I thought you were directing my
20 attention to page three. Okay.
21 Q. Now, on page four.
22 A. On page four.
23 Q. Are you with me, smoking and cancer?
24 A. well, I don't know. It depends upon where
25 you are. The subheading, "Smoking and Cancer", in

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1 italics?

2 Q. "Smoking and Cancer."

3 A. Okay. I am with you.

4 Q. All right. Read that first sentence.

5 A. You want me to read it. "Additional

6 evidence substantiates that previous findings that

7 cigarette smoking is the main cause of lung cancer in

8 men."

9 Q. Do you agree with that statement, that

10 cigarette smoking is the main cause of lung cancer in

11 men?

12 MR. SHEPPARD: Object to the form as

13 calling for him to agree or disagree with the testimony

14 of someone else.

15 A. Well, this is not an area that I have done

16 any work in, and I don't have any independent basis for

17 passing judgment on that. I am certainly prepared to

18 believe that it is a significant factor in the

19 occurrence of cancer of the lung. Whether it is the

20 main one, the distinction is something else. It is

21 another matter, how frequent it is and it is an

22 avoidable risk.

23 Q. And avoidable, how would you avoid the risk

24 of lung cancer caused by smoking?

25 MR. SHEPPARD: Object to the form. It is

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1 argumentative.

2 A. That's a question, huh? I suppose by not

3 smoking is one way.

4 (Exhibit No. 7 was marked for

5 identification.)

6 Q. Doctor, let me show you one more. We will

7 jump up to 1994 and another report of the Surgeon

8 General, this one entitled "Preventing Tobacco Use

9 Among Young People". And we will mark that as the next

10 exhibit.

11 Would you take a look at the report, sir,

12 and my questions are going to be similar. I'd like you

13 to take a look at the panel convened by the Surgeon

14 General to pass on this matter and tell me if you have

15 ever worked with any of the individuals.

16 A. You have got a poor copy here.

17 Q. It's actually all right, sir. That page

18 four ends where it ends. That's a carry over from

19 another page, as you can tell.

20 A. No, I can't tell. It is a poor copy.

21 Q. Look at the names.

22 A. So we are now on page?

23 Q. Roman numeral five.

24 A. I don't see the Roman numeral. It must be

25 five. It precedes six. But I don't see it.

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Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 MR. SHEPPARD: Have you got yours? It
2 doesn't seem to have it on it.
3 MR. WESTBROOK: Mine has got a weak Roman
4 numeral. The next copy must have lost the Roman
5 numeral. That's the page.
6 A. Okay. That's the page you have represented
7 as being Roman numeral five. All right. I am looking
8 at it.
9 Q. Okay. Go on. Look at five, six, seven,
10 eight, nine and ten, listing of contributing authors,
11 reviewers, fellow contributors; and tell me if you have
12 ever worked with any of the individuals who are listed
13 as having contributed or reviewed the work of this
14 panel resulting in this publication.
15 A. Not to my knowledge.
16 Q. Doctor, I counted up the contributing
17 authors and the reviewers, and I got approximately 98
18 physicians or scientists. To your knowledge, then, you
19 haven't worked with any of those people professionally?
20 A. Well, I don't know how many there are. I
21 did not count them. But to my knowledge I haven't
22 worked with them. There are some that it would be very
23 difficult to imagine. For example, Victoria,
24 Australia, I doubt there is any way I would ever see
25 that person. I don't recognize the names of any of

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1 them, even those that are at facilities that I have on
2 occasion attended.
3 Q. All right. Doctor, are there physicians
4 and scientists in your opinion who have a professional
5 reputation as cancer researchers in the area of
6 tobacco?
7 A. Probably. I have not searched for such
8 people.
9 Q. Do you regard yourself as one of those
10 people?
11 A. No.
12 Q. Take a look, sir, in this 1994 report by
13 the Surgeon General.
14 A. Exhibit 7.
15 Q. Exhibit 7. And in summary, page six. And
16 I want to direct your attention to the very first
17 portion of the summary, which begins on page six.
18 A. Summary, and then below that, introduction.
19 Q. Yes, sir. The introduction. The first
20 sentence says, "The health effects of cigarette smoking
21 have been the subject of intensive investigation since
22 the 1950s." Does that agree with what you have
23 determined in your professional reading, sir?
24 A. Well, I suppose it is subject to
25 interpretation as to how intensive it is, but certainly

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1 He certainly has a favorable reputation.

2 Q. All right. And I am interested in your

3 opinion, sir.

4 A. Well, I find that it is a poor idea to

5 engage the word "authoritative" with respect to anyone,

6 because the moment you acknowledge them as authority,

7 you say that whatever they say about anything is

8 correct. And I don't choose to do that with Dr. Dahl.

9 I don't think he would do that about himself if he

10 understood the connotation. I am sure that he has

11 changed his mind from time to time about things, and

12 therefore he can't be invariably correct.

13 Q. Do you regard any physician or scientist in

14 this world as an authoritative figure on any aspect of

15 medicine or science?

16 A. If you mean by that that everything they

17 say is correct, no. There are certainly people with

18 more experience and more ability, that have published

19 more and spent more time in all sorts of things, and

20 you would expect they would have better opinions than

21 those that do not measure up to all those aspects. On

22 the other hand, they may not be correct.

23 Q. Let's look at the second sentence of the

24 introduction. It says, quote, "Cigarette smoking is

25 still considered the chief preventable cause of

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1 premature disease and death in the United States",
2 unquote. I take it that you would agree with that
3 statement?
4 MR. SHEPPARD: I object as leading and
5 asking him to speculate as to what these people in
6 Exhibit 7 meant.
7 MR. WESTBROOK: Counsel, please let's --
8 MR. SHEPPARD: Speculation.
9 MR. WESTBROOK: Let's conduct ourselves
10 according to the case management order. Thank you.
11 A. Well, I just don't have an opinion whether
12 that's correct or not correct. It certainly is
13 avoidable.
14 Q. The next sentence, which says, quote, "As
15 was documented extensively in previous Surgeon
16 General's reports, cigarette smoking has been causally
17 linked to lung cancer and other fatal malignancies,
18 arteriosclerosis and coronary heart disease, chronic
19 obstructive pulmonary disease and other conditions that
20 constitute a wide array of serious health
21 consequences", unquote. Do you agree with any or all
22 of that, doctor?
23 MR. SHEPPARD: Speculation.
24 A. Well, I just don't have an opinion about
25 that.

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1 Q. So you wouldn't disagree with this panel,
2 then, which has stated this after its study?
3 A. I think it stands on its own feet. I don't
4 have to endorse that.
5 Q. And you have no basis to disagree with it,
6 do you?
7 A. I haven't done any independent
8 determination.
9 Q. So you have no basis to disagree with it?
10 A. That's correct, I don't have a basis to
11 disagree with it. I simply don't have a feeling that I
12 need to endorse that. It's a relatively broad brushed
13 statement, and I just don't have an opinion about it.
14 Q. All right. Doctor, other than the tobacco
15 company attorneys, has anyone ever sought out your
16 opinion on any aspect of cigarette smoking and health?
17 A. I don't recall anyone that's done that. I
18 can recall people that have asked me to look at slides,
19 and I have told them I can't do that. But I don't
20 believe anybody has asked me about causation. I can't
21 tell what the cause is from looking at a slide.
22 Q. All right. When you say people have asked
23 you to look at slides, what people other than the
24 tobacco company attorneys have asked you to look at
25 slides in connection with cigarette smoking and health?

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1 A. Well, Howard Acosta asked me to look at
2 slides.
3 Q. Who did?
4 A. Howard Acosta.
5 Q. And who is Howard Acosta?
6 A. He is an attorney that has on occasion
7 engaged me in other things.
8 Q. And Mr. Acosta asked you to look at slides
9 in connection with a cigarette smoking, lung cancer
10 case?
11 A. Yes. I told him I couldn't do that.
12 Q. And why did you tell him you couldn't do
13 that?
14 A. Because I can't be in a conflicted
15 position. I told him that.
16 Q. All right. How would you be in a
17 conflicted position by looking at Mr. Acosta's slides?
18 A. Well, I presume he intends to assert a
19 claim on behalf of someone.
20 Q. Against who?
21 A. I don't know against whom, but I presume
22 against defendant tobacco companies.
23 Q. All right. Well, if you were not
24 consulting for the tobacco companies in that case, why
25 would you be in a conflicted position to look at

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1 Mr. Acosta's slides on behalf of the injured person?
2 A. I just think it's a poor idea to get in a
3 position where you have agreed to look at slides for
4 one party and then begin to look at slides for the
5 other. It's too difficult to keep separate.
6 Q. But if the facts are the facts, doctor, why
7 does it make a difference who you are consulting for?
8 A. It doesn't make any difference to me.
9 Q. All right. Then why did you turn down
10 Mr. Acosta?
11 A. For that reason.
12 Q. What reason?
13 A. Because I can't be on both sides of
14 something like this or be perceived in a circumstance
15 of being on both sides.
16 Q. Aren't you on both sides of other types of
17 civil litigation?
18 A. Yes, but I generally know the people
19 involved there. And here I have absolutely no
20 knowledge of how far this goes and things of that sort.
21 Q. What do you mean by "how far this goes"?
22 A. I have no idea what companies are involved,
23 and there are whole series of collateral issues.
24 Q. What do you mean by collateral issues?
25 A. Individual claims to be asserted.

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1 Q. All right. Had you been contacted by the
2 tobacco companies to consult with them on the Acosta
3 case?
4 A. No. Not to my knowledge. Because he
5 didn't tell me the nature of the case. I simply
6 explained to him that I had looked at slides and it
7 probably was not a good idea for me to look at slides
8 for parties on both sides.
9 Q. Okay. But by parties on both sides, do you
10 mean that since you have looked at slides and are
11 consulting with the tobacco companies that you do not
12 intend to consult at all with anybody on the other side
13 of tobacco litigation?
14 A. I have so much to do that I can pick and
15 choose, and I do not want to have my life complicated
16 by having people assert that somehow or other I have
17 been compromised in their case.
18 Q. And what people would assert that you had
19 been compromised?
20 A. No one, because I am not going to do it.
21 Q. All right. But what was your concern about
22 somebody asserting that you had been compromised?
23 A. My concern is that attorneys perceive, if
24 things do not go the way they wish, that someone may be
25 responsible. I just don't want to be responsible for

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1 that.

2 Q. Are you concerned that the plaintiff's

3 lawyer would be unhappy with you having consulted for

4 the tobacco company? Are you concerned that the

5 tobacco companies would be unhappy with you consulting

6 with the plaintiff's lawyer?

7 A. Both.

8 Q. Did Mr. Acosta say he didn't want to use

9 you when you told him you were consulting with the

10 tobacco companies or did you turn Mr. Acosta down?

11 A. Well, that would be a matter of

12 interpretation, but my belief is I told him I didn't

13 choose to do it.

14 MR. WESTBROOK: Off the record. You want

15 to take lunch?

16 (Luncheon recess from 12:30 to 1:30 p.m.)

17 BY MR. WESTBROOK:

18 Q. Doctor, let me take you back to the days

19 when you used to smoke for a few minutes.

20 Is there a reason you are laughing?

21 A. Well, that's a while. Yeah.

22 Q. All right. Let me just take you back there

23 and ask you: At the time you were smoking, what did

24 you think was in the cigarettes you were smoking?

25 A. What did I think was in it? I thought

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1 there was a leaf tobacco that was cut.

2 Q. And did the cigarettes that you smoked have

3 some kind of a wrapping?

4 A. Yes, there is a wrapping that held it. As

5 I recall, it was paper.

6 Q. Okay. And I take it through the years,

7 even though you haven't smoked yourself, you have seen

8 many cigarettes of people smoking them out and about;

9 that's accurate, isn't it?

10 A. As far as I am aware that's an accurate

11 statement. I am not an expert on cigarette composition

12 or, you know, how common that is. I just don't know.

13 But yes, sir, I periodically see it, yeah.

14 Q. And today do you have any different

15 understanding of what's in a cigarette than you did

16 when you were smoking?

17 A. Well, I suppose as one matures and has

18 experience, one knows more things. And I am not sure

19 my fund of information is increased very greatly.

20 Q. What more do you know about cigarette

21 composition today in 1997 than did you back in your

22 twenties when you were smoking them?

23 A. It's hard to determine. I think I knew the

24 components at that time as I do now.

25 Q. Okay. Same understanding?

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1 A. Yeah, pretty much. If there has been a
2 change, I'm not really aware of it.
3 Q. All right. Is there a field of medicine
4 known as preventive medicine?
5 A. I don't know if that has a board status or
6 not. There are people that express an interest in
7 that. Whether or not there is some sort of special
8 training program and boards and is a full-fledged field
9 is another matter. I don't know that.
10 Q. Now, in your practice, doctor, is it fair
11 to say that normally by the time you get involved in
12 some person's case, that person is either sick or
13 injured?
14 A. Well, it may be dead.
15 Q. Or dead. Sick injured or dead?
16 A. Yeah, for the most part I probably don't
17 see people that don't have some medical problem.
18 Q. All right. And then there are some
19 physicians, whether it's under a board certification or
20 not, but there are some physicians, are there not, who
21 specialize in trying to prevent people from getting
22 sick, which I have called preventive medicine; you are
23 aware of that, aren't you?
24 A. Sure. There is a guy on the radio that
25 sells vitamin preparations and things like that, talks

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1 about this area it seems like almost every time I turn
2 it on in the morning.
3 Q. Do you practice preventive medicine at all
4 in your profession?
5 A. No. I really don't deal with patients in
6 the common manner by which doctors usually do. I
7 generally provide information, laboratory results,
8 things of that sort. And I don't have a direct
9 relationship with patients, so advice is not something
10 I commonly give them.
11 Q. Is it fair to say, then, that you do not
12 practice preventive medicine?
13 A. Well, I don't know. As a matter of asking,
14 if I brush my teeth or something? I just -- I don't
15 know what you have in mind. I am not a preventive
16 medicine type doctor, if that's what you intend to
17 inquire about.
18 Q. Okay. That's fair enough. Now, doctor, I
19 want to focus for a few minutes on the billing records
20 that you gave me this morning. And we will mark these
21 as the next exhibit, 8.
22 (Exhibit No. 8 was marked for
23 identification.)
24 MR. SHEPPARD: You are going to mark all of
25 the different records as Exhibit 8?

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1 MR. WESTBROOK: I think we can just mark
2 them together, yes.
3 MR. SHEPPARD: Okay. All right. I am sure
4 they don't have a copy machine in this restaurant so we
5 will do the best we can with these going back and
6 forth.
7 THE WITNESS: Okay.
8 Q. Doctor, the first --
9 A. As a matter of curiosity, why did you pick
10 a restaurant?
11 MR. WESTBROOK: Off the record.
12 (Off the record discussion)
13 BY MR. WESTBROOK:
14 Q. Doctor, if I can, let me come around and
15 let's just run through what we have here. Then you
16 verify it, and then we'll all know what's in the
17 record.
18 A. Uh-huh.
19 Q. I have first, on November 7th, 1996, a
20 statement from you to Mr. Borman at the Shook, Hardy
21 firm?
22 A. Uh-huh.
23 Q. Two pages?
24 A. It looks like it.
25 Q. Then next I have a transmittal letter from

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1 Mr. Borman, December 3rd, 1996, to you, enclosing his
2 firm's check for $896, along with some kind of an
3 accounting sheet attached to it?
4 A. I think that's the skirt of the check.
5 Q. Okay. Skirt of the check. Two pages.
6 Then next -- Let's back up just a second. The first
7 document we looked at, the November 7th, 1996 billing,
8 was for attorney general claims, as you headed it?
9 A. Yes, that's the way it appears to be
10 entitled, yes.
11 Q. All right. Now, the next billing
12 correspondence I have from you to the --
13 A. Uh-huh.
14 Q. -- Shook, Hardy firm, I assume, although it
15 is not listed, Carol Lundgren-Bron of Kansas City?
16 A. Same address. I would assume that.
17 Q. I would. I didn't know if you would or
18 not.
19 A. Yeah, I would.
20 Q. Okay. Is for some services in January for
21 a Maudie Elizabeth Harvey matter?
22 A. Uh-huh.
23 Q. Was that an individual case on which you
24 were asked to consult by the Shook, Hardy firm?
25 A. Well, I -- I don't know what you mean by

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1 individual case. It is a case of one person. That's
2 her name.
3 Q. Okay.
4 A. And it included incomplete medical records
5 which I read over. They obviously are pretty
6 voluminous because it took me a long time to do it.
7 Q. That's an individual claim as far as you
8 know?
9 A. I -- I don't know the style of these
10 claims. I really don't know that I can directly answer
11 your question. It is one person, if that's the thrust
12 of your question. It's one person.
13 Q. And the records you looked at were for that
14 one person?
15 A. Well, unless there is something in there by
16 mistake from somebody else. I think there is one of
17 these cases -- I have forgotten which one it is --
18 where there is some records from somebody that is
19 completely unrelated that just by mistake were
20 included. But, yeah, that's all for one person.
21 Q. All right. Did you reach any conclusion --
22 A. No.
23 Q. -- after reviewing that matter?
24 A. I am sorry. I didn't let you complete your
25 question.

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1 Q. Did you reach any conclusion following your
2 review of Ms. Harvey's medical records?
3 A. No.
4 Q. The next document I have is a February 3rd,
5 1997 letter from Mr. Borman enclosing a check paying a
6 January 24th statement, correct?
7 A. It appears so. It doesn't have a copy of
8 the check, but that seems like a reasonable assumption,
9 yeah. There are some --
10 Q. I just want to see if the copy of the check
11 is in here. Okay. I am going by what you carried
12 over, so we will assume there was a check attached, but
13 it wasn't copied, at least --
14 A. Oh, it is definitely not copied. I don't
15 know whether it is attached or not. I couldn't tell
16 you that.
17 Q. You haven't complained to the Shook, Hardy
18 firm that they sent you a letter with no check, have
19 you?
20 A. No.
21 Q. Okay.
22 A. Not to my recollection.
23 Q. All right. Next I have a February 18th,
24 1997 statement from you to Ms. Lindgren-Bron in the
25 matter of Lou Ella Brent?

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1 A. Right.

2 Q. Was that again from reviewing the medical

3 records on an individual?

4 A. It's just one person, sure. It's an

5 individual.

6 Q. Did you reach any conclusion on that case?

7 A. No.

8 Q. Do you recall why you didn't reach any

9 conclusion?

10 A. Well, I can tell you that about all of

11 these, and that is that the records are incomplete,

12 they don't come up to date, and I have not seen any

13 histologic material. And fundamentally I am a

14 pathologist, and that is one of the things I really

15 look at.

16 Q. Going back to the Maudie Elizabeth Harvey

17 matter, do you recall whether that was a claim of lung

18 cancer?

19 A. I don't recall.

20 Q. Do you recall anything about --

21 A. No, I couldn't distinguish between these

22 various cases. I have not really come to a conclusion

23 about them.

24 Q. All right. On the same date,

25 February 18th, 1997, I have a statement from you to

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1 Ms. Lindgren-Bron in the Jerry E. Randall matter?
2 A. Yes.
3 Q. All right. And you didn't come to any
4 conclusion in that case, I assume?
5 A. No. That is correct.
6 Q. On the --
7 A. I think there is -- I think there is one
8 conference for three different cases, and there are
9 three different statements for the three different
10 cases. You will see that each of them was dated the
11 18th?
12 Q. Yes, three statements are dated the 18th.
13 A. Right. And what I have done is I prorated
14 that conference between the three of them. I think it
15 is, what? Four-tenths of an hour for one and
16 three-tenths of an hour each for the other two. I
17 don't know that there are -- yeah, that's correct.
18 There are probably only three of them at that time.
19 Q. Okay. And so you prorated the February 14
20 conference that you had among three cases, and then you
21 charged individually for the review of the medical
22 records in each case?
23 A. Sure. Yes.
24 Q. Okay.
25 A. Uh-huh.

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1 Q. And the third bill that you sent on
2 February 18th was for Annie L. Daughtry, correct?
3 A. Yes.
4 Q. Okay. And then the next document I have is
5 a March 7th 1997 letter from Keith Borman saying,
6 "Enclosed is our check in payment of your
7 February 18th consultancy statement"?
8 A. Okay. I don't know whether he paid one of
9 them in distinction to the other two or whether he paid
10 all of them or, you know, I just don't have a
11 recollection of that.
12 Q. All right.
13 A. I frankly don't become worried until people
14 don't pay me for at least 90 days so I -- Attorneys
15 sometimes don't pay immediately.
16 Q. All right. And then the next document I
17 have is a March 12th, 1997 billing statement from you
18 to Ms. Lindgren-Bron in the matter of Annie Bell
19 Griffin, correct?
20 A. It appears to be, yes.
21 Q. All right. And after you read the medical
22 records in Ms. Griffin's matter, did you form any
23 opinion?
24 A. No.
25 Q. Then the last next and last document I have

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1 is a document that is photocopied somewhat off center
2 and appears that it possibly had something underneath
3 it for "Re: Case review" for the review of another
4 case, correct?
5 A. I don't know that that's correct.
6 Q. Okay. Can you tell what case you were
7 charging for on the March 14th, 1997 statement?
8 A. Yes. I can tell you that I allocated that
9 against these four cases here -- or five cases, excuse
10 me, my numbers.
11 Q. Okay.
12 A. 2689 and 2701 and 2702 and 2703 and 2711.
13 Q. Those numbers appear on the bottom of your
14 letter?
15 A. Correct.
16 Q. Those numbers are in fact the numbers of
17 the previous four cases we discussed, Ms. Brent,
18 Mr. Randall, Ms. Daughtry, and Mr. Griffin; could you
19 verify that?
20 A. Okay. 01 is Randall. 02 is Daughtry. 03
21 is Brent. And 11 is Griffin.
22 Q. Okay. Who is 2689?
23 A. That's the first file that was opened on
24 the initial consultation. I don't know who that is.
25 Q. That is not the attorney general's matter,

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1 is it, which is 2643?

2 A. Yeah, I don't know what the number is.

3 Q. What significance do the numbers have,

4 2689, 2701? Is there some code that tells you when the

5 file came into your office?

6 A. No, there is no code that does that. I

7 have an access list which will tell me when they came

8 in.

9 Q. Do your case files start from zero, so this

10 number 2711 is the 2,711th matter that you have

11 consulted on in some period of time?

12 A. You shouldn't attach that significance to

13 that number because it -- well, it wouldn't begin at

14 zero anyway. It would begin at one. But initially

15 when I began assigning numbers, I began at 500 because

16 I had quite a large number that I hadn't given numbers

17 to in the past. So I went backwards from 500 to 1.

18 And as time went on, I gave them all numbers, and

19 surprisingly it came out fairly close. Well, 11 or 12

20 off or something like that. It was really surprisingly

21 close if I remember correctly. So there is a gap in

22 there. And I think there are probably a couple of them

23 that have numbers like .5 or something after it,

24 because either it was not given a number when it should

25 have been or it was two separate files that I hadn't

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1 recognized as two files initially. So you can't derive
2 any precise number from that.
3 Q. All right. Did you meet with anybody in
4 preparation for this deposition?
5 MR. SHEPPARD: I don't mean to interrupt
6 your train of thought, but may I have a brief
7 discussion on or off the record just to make sure that
8 you understand how --
9 MR. WESTBROOK: Sure.
10 MR. SHEPPARD: Either way you want it, you
11 want to have it on the record?
12 MR. WESTBROOK: I don't want --
13 MR. SHEPPARD: I just want to make the
14 statement. As you know, as it is reflected in Carol
15 Lindgren-Bron's letter to you that transmitted these
16 documents, there is a statement on the first page in
17 respect to the medical records of certain recipients of
18 assistance in Mississippi. And I don't think that was
19 directly asked of the doctor, but it is my impression
20 that those recent records that you were asking about in
21 the billing records were names of those recipients. Is
22 that --
23 THE WITNESS: That's, yes, my --
24 MR. SHEPPARD: Okay.
25 THE WITNESS: -- best belief, yeah.

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1 MR. SHEPPARD: Because at times you
2 referred to them as individuals and then as cases. And
3 I just wanted to make sure that that was a situation
4 that was clarified.
5 MR. WESTBROOK: Okay. I appreciate that.
6 Let's see if we can clear it up on the record.
7 BY MR. WESTBROOK:
8 Q. Doctor, is it accurate that the names of
9 the four individuals who we ran through on the billings
10 are individuals who you understand to be connected some
11 way with the state of Mississippi's case?
12 A. Yes.
13 Q. Okay. And as I understand, doctor, as of
14 today you have reached no opinions concerning those
15 four cases --
16 A. No.
17 Q. -- in any respect?
18 A. Right. That is a correct statement. I
19 have reached no opinion. The way the question is
20 worded, it's hard to know whether the appropriate
21 answer is yes or no. But I have reached no opinions on
22 that.
23 Q. Okay. Let me refer you back now to your
24 letter of November 7th, 1996 to Mr. Borman that we have
25 marked as Exhibit 5. Do you know when you dictated

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1 that letter, sir?

2 A. No. But it was sometime prior to

3 7 November. I don't know what day of the week that is.

4 Q. Take a look at the first two pages of your

5 billing records, which are Exhibit 8. And there is

6 some time entry there in November for dictation of

7 letter, correct?

8 A. Yeah.

9 Q. Okay. On what date is it recorded that you

10 dictated your letter?

11 A. It says five.

12 Q. Okay. November 5th?

13 A. Well, that is what it would be, 5 November

14 1996. That's November 5th, right.

15 Q. On what day did you record time for

16 reviewing the medical articles?

17 A. On what day? It says November 5th.

18 Q. Okay. Do you recall how long you had the

19 medical articles in your possession before you read

20 them?

21 A. No.

22 Q. Returning to your billing records, sir, we

23 see that -- is it accurate that the first contact on

24 this matter with defense lawyers was October 1st?

25 A. Well, that's what it says. Whether that is

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1 accurate or not is another matter. I don't know. I
2 assume it is, but I don't know that for a fact.
3 Q. Okay. When you sent your billing records,
4 you attempted to be as accurate as you could be, didn't
5 you?
6 A. Well, I attempted to be reasonably careful,
7 but that doesn't mean I am always accurate. I try to
8 be but. . .
9 (Exhibit No. 9 was marked for
10 identification.)
11 Q. Doctor, let's mark as Exhibit 9 a fax cover
12 sheet dated February 18th, 1997 from your office to
13 Ms. Lindgren-Bron of the Shook, Hardy firm, consisting
14 of the cover sheet, a sheet entitled deposition
15 agreement, a third sheet entitled "Re: Deposition
16 arrangements", and a fourth sheet which has some pages
17 out of the phone book. Take a look at that if you
18 would, please, doctor.
19 Is the document that you entitle deposition
20 agreement, which is the second page of this exhibit, a
21 standard document that you send out to lawyers who are
22 retaining you in cases?
23 A. I send it out frequently, yes.
24 Q. Okay. The third sheet entitled "Re:
25 Deposition Arrangements", is that another standard

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1 sheet that you send out to attorneys who are retaining
2 you?
3 A. I don't always send that out, but I do send
4 it out on occasion, yes.
5 Q. All right. How do you determine when you
6 are going to send it and when you are not?
7 A. Individually.
8 Q. Okay. Did you make any specific
9 determination as to why you should send it out in this
10 particular case?
11 A. No.
12 Q. And in the third paragraph of that
13 document, entitled "Deposition Arrangements", --
14 A. Uh-huh.
15 Q. -- you state, quote, "Nonpayment, delays in
16 payment, denial of costs incurred at request, arbitrary
17 reductions of amounts as little as a few dollars appear
18 more and more frequently", unquote. What are you
19 talking about there, doctor?
20 A. Well, I am just talking about how I have
21 difficulty on occasion collecting for a bill I sent for
22 deposition. In the past, what I did was I would
23 schedule depositions in my office, and I would just
24 simply send people the bill. And if they asked me to
25 do something like make copies, I would send them a bill

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1 for 15 cents a copy. And if they asked me to make
2 photographs, I would send them a bill for a tenth of an
3 hour to send the photographs out to be copied, plus the
4 bill for the photographs, and things of that sort. And
5 I found that people didn't pay those. And they just
6 don't pay deposition amounts.
7 And I have had people on occasion on both
8 sides refuse to pay me anything for the amount of time
9 I spend correcting the deposition transcript, which I
10 think is an essential aspect. I don't know what your
11 experience has been, but my experience is that no
12 matter how good court reporters are, they cannot be
13 infallible, and they do make mistakes, even if it's
14 such things as putting the letter "A" in place of the
15 word "B". And sometimes it changes meanings. I think
16 it is important for witnesses in anything that is at
17 all complicated to read and correct the deposition.
18 And if both sides refuse to pay for that, that is a
19 cost I incur that I just don't choose to incur.
20 Q. Were you intending by this notice to let
21 the lawyers who retain you know that you expected to be
22 paid for all the time you put in on a matter and not to
23 have quibbling over things?
24 A. Oh, I don't think I would have any problem
25 with the people that engage me. I don't know what it

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1 is like in Mississippi, but in Florida, which is my
2 most common venue, the person responsible for paying is
3 the person that sets the deposition. And those are
4 generally people that create problems, not the ones
5 that engage you.
6 See, I have never laid eyes on you before.
7 There is no reason for me to think that you are an
8 agreeable, nice person in advance.
9 Q. Did you form any opinion in advance that
10 the person taking your deposition in this case might
11 not be an agreeable or nice person?
12 A. No. I just am not planning on taking the
13 risk. It's a hazard.
14 Q. Have you had any trouble being paid by the
15 Shook, Hardy firm for the work you have put in?
16 A. Not to my recollection. I would say that
17 the people that engage me generally pay.
18 Q. Now, doctor, in preparation for this
19 deposition, this week have you met with anyone?
20 A. This week, no. Except this morning they
21 came to my office. And I think the principal thing was
22 being able to get here.
23 Q. Okay. Did you meet with anybody prior to
24 this week in preparation for this deposition?
25 A. Yes. Ten days or two weeks ago, something

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1 like that, Ms. Bron and Mr. Sheppard came.

2 Q. And how long did you spend with them?

3 A. Several hours.

4 Q. Okay. Did you review any documents other

5 than those that have been produced to us or that you

6 brought with you today?

7 A. No.

8 Q. Have you sent a bill yet for that time,

9 sir?

10 A. I don't know. Possibly not. I just don't

11 know.

12 Q. Did you go back and review the medical

13 articles that you had previously reviewed back in

14 October?

15 A. No. I saw no reason to.

16 Q. Did you discuss the individual cases, those

17 four individual cases or matters, in connection with

18 your meeting 10 days ago?

19 A. Only to the extent, if I recall correctly,

20 that either that time or subsequently I have been told

21 that there were additional records that should become

22 available and likely some of the slides.

23 Q. In reviewing the medical records in those

24 cases, am I correct there is four of them, sir?

25 A. I think so. I am not sure. There might be

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1 five, but I think there are only four.

2 Q. In reviewing the medical records in those

3 four cases, what were you looking for?

4 A. Well, I didn't have my mind set on anything

5 that I was looking for. I simply start at the

6 beginning and go to the end and stop. And I turn each

7 page. And to the extent that I am able, I read it.

8 And I may make marks on it as I go, so that the next

9 time through I will have less difficulty finding what I

10 found the first time.

11 Q. All right. Do you have those medical

12 records in your office, sir?

13 A. Yes, I believe so. I think they are all

14 there.

15 Q. And what kinds of marks did you make on the

16 medical records when you went through them?

17 A. Well, it varied, I'm sure. What I commonly

18 do is asterisk something or circle it or in some cases

19 underline or something of the sort, so that the next

20 time through it's easy to find it.

21 Q. Now, you say you were turning the page

22 going from one page to another. Did you have in mind

23 that you were looking to see whether these people had a

24 particular disease or not or --

25 A. No. I was simply going through in the way

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1 I commonly do with medical records to define the
2 problems.
3 Q. You were attempting to define the medical
4 problem the person had?
5 A. I think that's the principal thing, yes.
6 Q. Were you able to define the medical
7 problems that these individuals had, or any of them?
8 A. Well, to some extent, yes.
9 Q. Okay. Were these records on individuals
10 who are still living or are they deceased?
11 A. I do not think there is a record of
12 fatality in any of the records, although I believe, if
13 I recall correctly, I have been told that one is
14 deceased.
15 Q. The one who is deceased, do you have any
16 opinion on cause of death?
17 A. No. I don't have any of the terminal
18 records is my best belief. There are gaps for a number
19 of months there, I am sure.
20 Q. Did all four cases to your knowledge
21 involve cancer of some sort?
22 A. That's my best recollection.
23 Q. Can you confirm a diagnosis of cancer in
24 any of those four individuals?
25 MR. SHEPPARD: Let me just object here. I

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1 think there has been prior discussions and you have
2 been advised of the defense position here. Dr. Willey
3 has articulated that -- his factual basis for it, that
4 these records are incomplete, he hasn't seen the
5 pathology that is the subject. These haven't been here
6 yet. And he is not, as you were advised, prepared to
7 offer opinions in respect to these records at this time
8 because he hasn't had an opportunity to review all the
9 information and formulate his opinions, so it would be
10 unfair for him and for you to have the knowledge about
11 his opinions at this time.
12 BY MR. WESTBROOK:
13 Q. Doctor, as you sit here today, have you
14 formed an opinion as to whether any of these
15 individuals had cancer?
16 A. That seems like a likelihood, but I don't
17 have an opinion about it. I simply have not seen any
18 of the slides.
19 Q. Doctor, did you play any role in selecting
20 the individuals whose records you would review?
21 A. Well, I presume that they were aware I was
22 a pathologist and that that knowledge played some part
23 in what cases I was sent to review. But I did not
24 myself have any active part in making a selection.
25 MR. WESTBROOK: Let's mark next the

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1 March 14th, 1997 letter from Ms. Lindgren-Bron to
2 Dr. Willey with attachments.
3 (Exhibit No. 10 was marked for
4 identification.)
5 MR. SHEPPARD: It is the March 14th letter?
6 A. In any event, the prior one is 9. And this
7 one is 10, so we are talking about 10.
8 (Off the record discussion)
9 BY MR. WESTBROOK:
10 Q. Doctor, this letter appears to be
11 Ms. Lindgren-Bron is sending you another copy of the
12 articles that the lawyers had previously sent you
13 because you had incorporated the ones that they
14 previously sent you into your library and couldn't find
15 them; is that accurate, basically?
16 A. Well, that's what it says, but I found them
17 subsequently so. . .
18 Q. Okay. In the set of articles that
19 Ms. Lindgren-Bron sent you -- and we have just the
20 cover pages attached here, which is fine.
21 A. Uh-huh.
22 Q. -- I see the article, "The Epidemiologic
23 Necropsy", is in that set. It is about -- it looks
24 like it is three from the back.
25 A. Uh-huh.

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1 Q. Okay. Is that the article that you think
2 you sent the lawyers?
3 A. Yeah, that's the article I think I sent
4 them. Maybe I didn't, but I think I did.
5 Q. All right. At least according to
6 Ms. Lindgren-Bron's letter, that's included in the
7 articles as the lawyers originally sent you, isn't it?
8 A. That's what it says.
9 Q. Do you want to check something in your pile
10 to verify that?
11 A. I just wanted to see where that article
12 falls in this collection.
13 Q. Okay.
14 A. I don't care. I don't know where McFarlane
15 has gotten to. But one of them I sent and one they
16 gave me. Which is which, I don't know.
17 Q. All right.
18 A. I stand corrected.
19 Q. Doctor, let's look at your Rule 26
20 disclosure statement for a few minutes, which is
21 Exhibit 4.
22 A. Uh-huh.
23 Q. Let's start from the last sentence of the
24 subject matter and anticipated testimony paragraph
25 which says --

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1 A. Last sentence okay.

2 Q. It says, "Dr. Willey may also be asked to
3 comment upon the opinions expressed by other witnesses
4 in this case and the evidence upon which they rely to
5 the extent such evidence or opinions are within the
6 scope of his expertise." Doctor, have you reviewed any
7 of the witness statements or deposition transcripts of
8 any other witnesses in this case?

9 A. No.

10 Q. All right. Can you comment today, doctor,
11 on any of the opinions expressed by any other witness
12 in this case?

13 A. I don't know the opinions expressed so I
14 don't think it is fair for me to comment on it.

15 Q. Okay. All right. Up to the first
16 sentence, doctor, which says, "Dr. Willey is expected
17 to testify concerning the inaccuracies of death
18 certificate diagnoses often relied upon in
19 epidemiological studies." And first, doctor, I want to
20 ask you, have you personally made any study concerning
21 the accuracy or inaccuracy of death certificate
22 diagnoses?

23 A. I have made no formal study. I merely have
24 experience in signing them, reading them, have
25 knowledge of the medical records of large numbers of

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1 cases.

2 MR. WESTBROOK: Let's mark as the next

3 exhibit a document entitled Certificate of Death.

4 (Exhibit No. 11 was marked for

5 identification.)

6 Q. Doctor, I am not sure if this is exactly

7 the form you use down here in Tampa, but do you

8 recognize this as the type of form that is normally

9 referred to as a death certificate?

10 A. Yes. It generally has a designation of a

11 state on the death certificate. And they are

12 substantially similar, although there are at least some

13 variations from time to time in state to state.

14 Q. Okay. If you notice as we go through this

15 discussion any variations that would be material to

16 your answer, if you would point them out to me, doctor,

17 I would appreciate that. I am not sure that will come

18 up.

19 MR. SHEPPARD: I just -- I am just -- I am

20 not sure here. Is this purporting to be an official

21 Mississippi certificate?

22 MR. WESTBROOK: No.

23 MR. SHEPPARD: It is kind of a generic --

24 MR. WESTBROOK: Generic death certificate.

25 MR. SHEPPARD: All right.

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1 A. It appears to be one prepared by redacting
2 material.
3 Q. This is taken from an actual death
4 certificate, that's correct, doctor. Doctor, look at
5 the first top third of the certificate, and tell me if
6 in your experience that certificate contains the usual
7 identifying information on the deceased and his or her
8 family, race, et cetera?
9 A. Down to?
10 Q. Down to number 20.
11 A. Number 20. Okay. It appears to
12 incorporate that standard information. I'm not sure
13 that all of every other one is represented here, that
14 this is necessarily completely correct, but it appears
15 more or less standard.
16 Q. That's fair enough. And then, doctor, am I
17 correct that questions 20 through 22 are questions
18 directed to the cause of death?
19 A. I don't believe that's correct.
20 Q. Okay. Over to the left, doctor, do you see
21 a box encompassing questions 20 through 22, cause of
22 death?
23 A. Yes.
24 Q. Okay. Does that indicate to you that those
25 questions have something to do with the cause of death

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1 category on this death certificate?

2 A. Well, that's what it says. But we're

3 looking at these parts here. And it says, for example,

4 21 is autopsy. And that certainly has nothing to do

5 with the cause of death. It just simply indicates a

6 scope of investigation.

7 Q. Of the cause --

8 A. As to whether or not an autopsy has been

9 done.

10 Q. Wouldn't that indicate whether an autopsy

11 had been done in contributing to determining the cause

12 of death?

13 A. Frequently they ask, has autopsy

14 information been used in compiling the cause of death.

15 And that's generally down on the form below, below the

16 bottom of this, is my best recollection. But in any

17 event, that may indicate whether an autopsy has been

18 done or not. It does not necessarily by itself

19 indicate that the autopsy information has actually been

20 used in determining the cause of death.

21 And unless I misunderstood your question,

22 you asked through 22. And there are a number of other

23 things present which don't really have to do with the

24 cause of death. 22a is actually the manner of death in

25 distinction of the cause. And 22b indicates the date

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1 of injury, hour of injury, things of that. And then it
2 has addresses and things of that sort. So despite the
3 fact that that box says cause of death, I really don't
4 think that necessarily has any relevance to 20, Part I
5 and Part II, which is, I think, that there -- is the
6 material that specifically asks for the cause of death.
7 Q. So when you review questions 20, Part I and
8 Part II are the two parts of the question that really
9 deal with cause of death?
10 A. Of the question. Well, they are the two
11 parts -- they are the two sections of this form that
12 deal with the cause of death.
13 Q. Okay.
14 A. An of course at the end it indicates
15 intervals between causes as ascribed.
16 Q. All right. And then a physician -- By the
17 way, can anyone who is not a physician fill out a
18 certificate of death?
19 MR. WESTBROOK: Legally?
20 A. Well, physicians sign them, but quite
21 commonly they are filled out by people that are not
22 physicians. The person that fills out the form for the
23 most part is the person with the most interest in it,
24 is undertaker or something, in my experience.
25 Q. And the physician signs the cause of death

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1 certificate?

2 A. Yeah. It requires a physician's

3 signature. It says name of attending physician, type

4 or print. Of course a large number of them are by

5 people that are not attending physicians.

6 Q. Are death certificates of people who die in

7 the hospital filled out in the hospital or do they fill

8 it out in the funeral home by the undertaker?

9 A. Well, I suppose it varies considerably.

10 And I don't know whether there is a different -- there

11 is a routine approach to that. My personal experience

12 with most of the ones that I have done is that they are

13 prepared by a secretarial personnel, medical examiner's

14 office, or by undertakers.

15 Q. Okay. And the physician then certifies the

16 cause of death as being correct?

17 A. The physician is the certifier, that's

18 correct.

19 Q. Now, question 20, Part I, in the

20 explanation, has statements. It says, "Conditions, if

21 any, which give rise to immediate cause, stating the

22 underlying cause last." Is that a normal convention,

23 that the immediate cause of death is stated first and

24 then the underlying cause is stated last?

25 A. That's my best recollection that they are

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1 usually arranged.

2 Q. All right. And which of the conditions --

3 excuse me. Which of the causes listed on a death

4 certificate does an epidemiological study pick up and

5 carry as the cause of death?

6 A. I don't know. It depends upon the

7 epidemiological study, I presume.

8 Q. And do you know of any epidemiological

9 study which looks at the immediate cause of death and

10 relies on that?

11 A. There probably are some. For example,

12 acute deaths due to heart failure. I have seen studies

13 where people have looked at a specific entry such as

14 that. But I have not done so in recent years.

15 Q. All right. I am asking you about

16 epidemiological studies, doctor.

17 A. Okay. I don't know of any.

18 Q. All right.

19 A. No, not of my knowledge.

20 Q. All right. In simplest analysis, doctor,

21 the immediate cause of everybody's death is that they

22 stop breathing, isn't that right?

23 A. Well, the mechanism that is commonly

24 recognized are the heart stops or the breathing stops

25 or. . .

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1 Q. And when a physician is certifying the
2 underlying cause of death, what does that mean to you?
3 A. That means a condition that produced
4 whatever the phenomenon is that caused the person to
5 die.
6 Q. Have you done any study, doctor, in your
7 area here, St. Petersburg area, to determine if lung
8 cancer is being over diagnosed or under diagnosed as
9 the underlying cause?
10 A. Have I done a study of this area? No, I
11 have not.
12 Q. And I think we covered before that you are
13 not familiar with the protocol that an oncologist or a
14 treating physician goes through in a case of suspected
15 lung cancer to determine whether the cancer is a
16 primary or a metastasis; is that right?
17 A. Well, I am undoubtedly knowledgeable about
18 certain of the elements, but I don't practice either of
19 those things and I am not familiar with their protocol,
20 no.
21 (Exhibit No. 12 was marked for
22 identification.)
23 Q. All right. Let's mark as the next exhibit
24 a chart from the National Center for Health Statistics,
25 U.S. Bureau of the Census, entitled "Age Adjusted

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1 Cancer Death Rates for Selected Sites, Males, United
2 States, 1930 to 1986".
3 Doctor, before we look at the chart, when
4 was the last time you filled out a death certificate
5 and determined the cause of a person's death?
6 A. I don't recall doing it this year. I have
7 certainly done it, I believe, last year. I am not
8 certain, though.
9 Q. Was that in a cancer case, sir?
10 A. It probably was, yeah.
11 Q. What type of cancer?
12 A. I think it was a mesothelioma.
13 Q. Have you ever testified in any asbestos
14 litigation, doctor?
15 A. I don't think so. I have seen some cases,
16 but I don't believe I have ever testified in one.
17 Q. All right. Have you been consulted by
18 attorneys in cases involving alleged asbestos-related
19 disease?
20 A. Occasionally.
21 Q. All right. Who did the attorneys who
22 consulted you represent?
23 A. Generally they represented claimants.
24 Q. Okay. And have you ever given --
25 A. I think there is one that was a workmen's

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1 comp claim that was a defense claim.

2 Q. And have you given any depositions in those

3 cases?

4 A. Possibly.

5 Q. Did I understand you to say that you signed

6 the death certificate in this mesothelioma case?

7 A. Yes, I think that's one where I did the

8 autopsy and I signed the death certificate.

9 Q. Who requested you to do the autopsy?

10 A. Family of the deceased.

11 Q. All right. And did you list mesothelioma

12 as the immediate cause of death or the underlying cause

13 of death?

14 A. I listed it as the immediate cause of death

15 because I didn't have any knowledge of the intervening

16 events prior to death.

17 Q. All right. How did you determine that this

18 person died of a mesothelioma?

19 A. Simply from looking at the magnitude of

20 disease and the wasting condition.

21 Q. How did you know that this was not a

22 metastasis from the lung parenchyma to the pleura?

23 A. Well, that's always a consideration as

24 whether a tumor is primary or secondary. On the other

25 hand, I don't recall specifically this case. But

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1 generally speaking, one looks at the histologic
2 appearance, the gross distribution, and there are a
3 number of special immunological and staining techniques
4 that are reasonably characteristic of mesothelioma in
5 distinction to cancers arising elsewhere, lung or for
6 that matter anywhere else.
7 Q. And did you do that staining or have that
8 staining done in this case?
9 A. I usually do. I assume I did.
10 Q. And did you satisfy yourself that this was
11 not a lung cancer that had metastasized through this
12 process?
13 A. Yes.
14 Q. All right. Is that the only autopsy that
15 you recall doing in the last year or so?
16 A. No. I did one last week. I do them
17 periodically. I don't do a large number. I would
18 say -- I hope to do less than a dozen a year. They are
19 hard work and. . .
20 Q. Other than the mesothelioma, can you recall
21 in the last several years any autopsies that you have
22 done in cancer cases?
23 A. Oh, I think I have done more than one of
24 them. I don't specifically remember the cases I have
25 done. The last, the last one, was a case where I

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1 examined after the medical examiner had done an
2 examination.
3 Q. And what kind of cancer was that?
4 A. Not a cancer at all.
5 Q. I was referring to cancer cases, doctor.
6 Other than this mesothelioma, do you recall any other
7 autopsies you have done in the last several years that
8 involved cancer?
9 A. Well, I am sure there have been some, but I
10 don't recall them. And I am sure there have been other
11 cases of mesothelioma, but I don't specifically
12 remember them.
13 Q. How about cases of lung cancer, do you
14 recall when is the last time that you signed a death
15 certificate listing the cause of death as lung cancer?
16 A. I don't, I don't recall.
17 Q. Do you recall in the last five years doing
18 one?
19 A. I probably have, but I don't recall any
20 specific circumstance.
21 Q. All right. Doctor, let's look at our chart
22 for a minute. From this chart, doctor, would you agree
23 with me that of all the cancers tracked on this chart,
24 that lung cancer shows the most significant rise from
25 1950 to 1985?

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1 A. Well, the chart is hard to read. I assume
2 that the lung cancer line is the solid line there. Is
3 that correct?
4 Q. Yes, sir.
5 A. It appears that that's the only one that
6 has a substantial upward movement.
7 Q. All right. Are you familiar at all,
8 doctor, with the statistics on the trend of smoking
9 incidence in the United States up through 1985?
10 A. No.
11 Q. Do you know what a latency period is,
12 doctor?
13 A. Yes.
14 Q. And how would you define latency period?
15 A. Well, it is susceptible to other
16 definitions, but latency period is an interval during
17 which a disease does not manifest although the cause is
18 present. An example would be an infection where there
19 is an interval between time the infecting agent enters
20 the person and the time when the person becomes ill
21 with the infection.
22 Q. Have you heard the statement that cancer is
23 generally a disease of old age; have you ever heard
24 that statement?
25 A. I have heard the statement. I have seen

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1 cancer in very young children. I have seen cancer in
2 placentas. And so it is not a statement which by
3 itself is uniformly correct. It's. . .
4 Q. Are you finished, doctor?
5 A. Yes.
6 Q. Okay. Would you agree, doctor, that cancer
7 incidence for most cancers rises with advancing age?
8 A. Most cancers, yes, probably.
9 Q. All right. With respect to that
10 mesothelioma you saw, doctor, what is the latency
11 period for mesothelioma from last exposure to the
12 carcinogen that caused it?
13 A. Well, the last exposure may have been very
14 recent. You are talking about the original exposure
15 that you believe caused that in distinction to the
16 last.
17 Q. Do you believe that the first exposure to a
18 carcinogen is the exposure that causes the cancer?
19 A. Well, I don't believe that, no.
20 Q. All right. Can you pick out an exposure
21 among, say, someone who has been exposed to a
22 carcinogen over a 20-year period and then some decades
23 later gets the cancer caused by that carcinogen, can
24 you tell which exposure caused that cancer?
25 A. Well, I cannot tell which exposure caused

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1 that. But moreover, most people supposed in some way
2 probably don't get cancer. So it is much more
3 complicated than that.
4 Q. Let's speak to our mesothelioma for a
5 minute, with that particular case.
6 A. Uh-huh.
7 Q. First of all, do you know what the latency
8 period is for development of mesothelioma?
9 A. Well, I know people say that exposure must
10 have occurred more than five, probably more than ten
11 years before the disease. I don't have any independent
12 basis for making much of a statement about that. On
13 the other hand, one could have had exposure to asbestos
14 two weeks before the person died of mesothelioma. In
15 fact, that case I was telling you about, the workmen's
16 comp claim, was a man that had cut asbestos tile as a
17 young person. And the workmen's comp carrier that was
18 involved with that had covered him when he worked as a
19 clerical person in a brake shop weeks before he died.
20 And the operation of the law, as I
21 understood it, was that the brake shop was responsible
22 despite the fact that, you know, it appears, assuming
23 that a latency period is a correct statement, it
24 couldn't possibly have, quote, caused, unquote, the
25 condition. So the legal determination of cause is

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1 something I have a great deal of difficulty with.
2 Q. And the legal determination of cause is
3 something that is made by judges and juries and not
4 doctors; you agree with that?
5 A. Well, it will have to be because I -- I
6 don't know how they can do that. I don't think they
7 are going to empanel any doctors to do it.
8 Q. I tend to agree with you there. Now, with
9 respect to tobacco and lung cancer --
10 A. I -- I hope you are not at a critical
11 moment. I want to take a break for a few minutes.
12 MR. WESTBROOK: Sure.
13 (Recess)
14 BY MR. WESTBROOK:
15 Q. All right. Doctor, with respect to tobacco
16 and lung cancer, do you have in your mind a period of
17 time that you would describe as the latency period
18 between exposure to tobacco smoke and the development
19 of lung cancer?
20 A. No.
21 Q. Do you have any general idea whether it's a
22 year versus ten years or six months versus twenty
23 years?
24 A. It's longer, but I don't know how long and
25 the circumstances.

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1 Q. Do you think it is longer than twenty years
2 on occasion?
3 A. It is forever on some occasions, yeah. I
4 have done any number of autopsies on elderly people
5 that don't have lung cancer who smoked.
6 Q. Does that tell that you smoking doesn't
7 cause lung cancer?
8 A. No. It is just not invariable as a cause.
9 Q. Everybody who smokes does not get lung
10 cancer; we can agree on that, can't we?
11 A. Most definitely.
12 Q. All right. Now, looking at the chart which
13 we have marked as Exhibit 12, the age adjusted cancer
14 death rates, --
15 A. Uh-huh.
16 Q. -- can you tell us, doctor, in your opinion
17 what is the cause or what are the causes of the
18 significant rise in lung cancer in this country since
19 1950 through 1985?
20 A. Well, we are now using the word that we
21 agreed that the trier of fact would have to determine,
22 which is "cause". There are a number of factors that
23 other people ascribe when they offer explanations.
24 Q. You say other people ascribe?
25 A. Yeah. I am not an expert on the causation

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1 of cancer of the lung.

2 Q. Okay. What I want to find out is: What

3 are your opinions, doctor; what do you believe is

4 responsible for the rise in lung cancer as shown on

5 this chart?

6 A. Well, I think there are multiplicity of

7 causes. And how these relate one to another and what

8 the magnitude of it is, the way these factors relate to

9 the ultimate development is not fully understood in my

10 judgment. I am aware of the allegations that smoking

11 is the principle reason for this. The simple statement

12 that smoking is increased and lung cancer has

13 increased, therefore they are related, seems to me to

14 overlook the fact, there are all sorts of things that

15 have increased at the same time, industrial exposure,

16 radon, certainly various chemicals, acytocaustic drugs

17 that are used in chemotherapy, irradiation, therapeutic

18 and probably to a lesser extent diagnostic radiation.

19 There are a number of potential things.

20 For example, golf is, to my way of thinking, not likely

21 related to the development of lung cancer, but golf is

22 a lot more common now than it was in 1930, and I think

23 it possibly has more or less the same curve up.

24 Q. Let's take the -- have you exhausted the

25 factors that --

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1 A. Oh.
2 Q. -- you believe may --
3 A. By no means.
4 Q. All right. Tell me what else you think.
5 A. Oh, I can't go on forever. But you can go
6 to any textbook, and they give you a list, plus there
7 is unknown. There are all sorts of things that are
8 unknown.
9 Q. Let's start with the factors that you have
10 given me so far. Radon. Have you ever seen a case of
11 lung cancer that you determined was caused by exposure
12 to radon?
13 A. No.
14 Q. Have you ever seen a case of lung cancer
15 that you determined was caused by some industrial
16 exposure?
17 A. No.
18 Q. Have you ever seen a case of lung cancer
19 that you determined was caused by therapeutic
20 radiation?
21 A. No.
22 Q. Have you ever seen a case of lung cancer
23 that you thought was caused by diagnostic radiation?
24 A. No.
25 Q. Have you ever seen a case of lung cancer

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1 that you determined was caused by cytocaustic drugs?
2 A. No.
3 Q. Have you ever seen a case of lung cancer
4 that you determined was caused by chemical exposure?
5 A. No.
6 Q. Have you ever seen a case of lung cancer,
7 doctor, that you determined was caused by anything?
8 A. No. That's not something I'm capable of
9 doing. You look at tissue, and you can't tell what
10 caused it. They all look alike. It doesn't matter
11 whether it's -- what the original cause was. It could
12 be hereditary. It could be anything.
13 Q. When doctors are trying to determine the
14 cause of cancer, doctors that do that, do they look for
15 a convergence of various scientific disciplines, such
16 as epidemiology, toxicology and other things?
17 MR. SHEPPARD: Object to form,
18 speculation.
19 A. It seems like a reasonable supposition, but
20 it is just not something I do.
21 Q. Okay. Now, understanding that you have
22 given me some factors that you have mentioned, can you
23 say, doctor, that any of those factors alone or in
24 combination are responsible for the rise in lung cancer
25 in this country as shown on the chart?

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1 A. No.

2 Q. Doctor, if chemical exposure were

3 responsible for the rise of lung cancer in this

4 country, would you expect lung cancer to be the only

5 cancer increasing at such a significant rate?

6 A. Well, I am not sure there aren't others

7 that are increasing at a significant rate. All you

8 have got here is a small sampling of cancers. And I

9 don't see any reason why industrial exposure wouldn't

10 be capable of doing that to lung in distinction to, for

11 example, prostate.

12 Q. Now, prostate is on the chart, and it is

13 not increasing at the rate that lung cancer is,

14 according to this chart, is it?

15 A. Well, I think that's probably a defect of

16 the chart, because lung cancer has received a lot of

17 attention. That's the reason they generated this

18 chart. But cancer of the prostate has gotten to be

19 extremely common. The older the person, the more

20 common it is. I would say the instance of finding

21 cancer of the prostate in people 70 years old is

22 appreciable, 20 percent, 30 percent.

23 Q. All right.

24 A. It is pretty substantial.

25 Q. Would you agree that prostate cancer is a

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1 cancer of old age?

2 A. It is more common in old age, just as

3 cancer of the lung is more common in old age. Of

4 course, the number of old people falls off too so. . .

5 Taking only the people that are a given age, the older

6 they are, the more common it is.

7 Q. Doctor, do you believe that for a

8 carcinogen to cause cancer that there has to be some

9 physical impact at the site where the primary cancer

10 develops?

11 A. Physical impact. I think a physical impact

12 is trauma or something. I am not -- I don't think

13 of --

14 Q. Let's think of it in more microscopic

15 sense. Do you think that for a carcinogen to cause

16 cancer that there has to be some physical presence of

17 the carcinogen in the vicinity of the area where the

18 primary tumor develops?

19 A. I don't know that I can specifically answer

20 that question.

21 Q. Do you have an opinion one way or the

22 other?

23 A. No.

24 Q. Okay. In the mesothelioma case, doctor,

25 did you look at the slides to see if there were any

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1 exposure?

2 A. I don't think so.

3 Q. Did your opinion go just so far as to

4 determine that it was a mesothelioma and then you

5 stopped?

6 A. That's my best recollection.

7 Q. Can you list for me, doctor, the cancers,

8 primary cancers of the body which develop without some

9 physical presence of the carcinogen in the vicinity of

10 the primary tumor?

11 A. I -- I couldn't answer the original

12 question. I can't answer this one either.

13 Q. Okay.

14 A. There are -- there are malignancies that

15 appear to be entirely hereditary and don't involve some

16 external cause as far as I know. Retinoblastoma comes

17 to mind as a reasonable example.

18 Q. When you say they are hereditary, what is

19 hereditary about the tumors?

20 A. I don't know. There are experts that deal

21 with that particular tumor, and I am not one of them.

22 Q. All right. Do you believe that for a tumor

23 to develop, the DNA of the cell has to be affected in

24 some way?

25 A. Probably is. I don't really have an

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1 opinion about that, though.

2 Q. All right. Doctor, have you heard it or

3 read it stated that cigarette smoke contains 40 to 50

4 carcinogens in it?

5 A. I don't know what number is involved, but I

6 have certainly seen that written.

7 Q. Do you know what nitrosamine is?

8 A. I am not a chemist. I am aware it's a

9 chemical that is found in smoke.

10 Q. All right. Have you heard the term TSNA?

11 A. No.

12 Q. Do you know what an NNK is?

13 A. No.

14 Q. Are certain carcinogens organ specific,

15 doctor, in your view?

16 A. They probably are, but I don't have any

17 opinion about that. I am just not an expert at

18 causation of malignancies.

19 Q. All right. Doctor, have you looked at any

20 statistics on lung cancer in United States males for

21 the period after 1986?

22 A. No.

23 Q. Do you know whether it's increasing or

24 decreasing?

25 A. I don't know.

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1 Q. Do you know anything, doctor, about how the
2 cell type of carcinoma in United States males has
3 developed over time?
4 A. Well, I have seen reports that seem to
5 indicate that there are more adenocarcinomas now and
6 fewer squamous cell and small cells. I don't know if
7 that is of any real relevance to me because all I do is
8 look at them and make an effort to diagnose them, put
9 them in the right pigeonhole.
10 Q. All right. Doctor, do you have an
11 opinion -- Looking at this chart which lists, for
12 instance, in the year 1980, approximately 71 lung
13 cancer deaths per 100,000 male population. Do you have
14 an opinion as to whether any of those lung cancers are
15 misdiagnosed and are actually some other cancer?
16 A. Well, I don't know specifically any one
17 case that's involved in that compilation of statistics
18 so I can't specifically answer that. All I can say is,
19 in my experience the accuracy of diagnosis is not
20 extremely great, so it would be reasonable to infer
21 that there are not only mistakes in that, but there are
22 mistakes in all these others too.
23 Q. I think we can agree that doctors are not
24 perfect. You will agree with that, won't you?
25 A. I will agree with that.

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1 Q. All right. That's why we sometimes have
2 medical malpractice cases, would you agree with that?
3 A. I am not sure that has any relationship to
4 the fact they are not perfect, no.
5 Q. Okay. And doctors --
6 A. Nobody expects them to be perfect, is my
7 judgment.
8 Q. And doctors can make mistakes?
9 A. And commonly do.
10 Q. All right. And do you have some basis to
11 believe, doctor, that the mistakes in diagnosis of lung
12 cancer favor overdiagnosis of lung cancer?
13 A. I think that's probable, but I don't have
14 any basis other than personal experience in seeing
15 cases of cancer diagnosed that are not.
16 Q. All right. And that's limited to the cases
17 that you have seen?
18 A. I can't imagine how it would be otherwise
19 with experience.
20 Q. Well, for instance, you could have reviewed
21 records of hospitals or records of cancer statistics
22 and gotten the slides and looked at them in cases other
23 than which you had been personally involved in.
24 A. I have not made a formal study of that.
25 Q. Okay. Let's look at an article that was in

http://legacy.library.ucsf.edu/tid/nhq07a00/pdf
Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 the group of articles that were produced to us, and it
2 is called "Factors Influencing Discrepancies Between
3 Premortem and Postmortem Diagnosis", by Battle, et al.,
4 and we will mark that as the next exhibit.
5 (Exhibit No. 13 was marked for
6 identification.)
7 Q. All right. Now, doctor, this is an article
8 by a number of physicians. Do you know any of those
9 physicians and apparently one Ph.D. and one M.S. in the
10 group?
11 A. No.
12 Q. Okay. And this article, doctor, as I
13 review it, looked at a number of cases to determine
14 whether the diagnosis of disease -- excuse me, whether
15 there had been disease that was undiagnosed in life.
16 Is that how you understand the article?
17 A. Well, it may be susceptible to that
18 interpretation. All I interpret, as the title says,
19 discrepancies.
20 Q. All right. Look at page 340, which is the
21 second page of the article. In the middle column I
22 want to read you a sentence or two, and then let's
23 discuss it.
24 At the top of the middle column. "The
25 present report concerns only cases in which a disease

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Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 present at autopsy was either diagnosed, (true
2 positives) or not diagnosed clinically (false
3 negatives). As a consequence, clinical diagnosis not
4 substantiated by autopsy (false positives) were not
5 evaluated, and it was not possible to determine whether
6 select diseases tend to mask the manifestations of
7 other entities in a specific fashion."
8 All right. Now, doctor, you understand
9 what that means, don't you?
10 A. Well, in part. I am not a statistician. I
11 understand what they are talking about. They are
12 talking about whether something is present or not that
13 was diagnosed clinically.
14 Q. Right. Now, but what they are saying is
15 that clinical diagnoses that weren't substantiated at
16 the autopsy were not evaluated; isn't that what it
17 says?
18 A. It certainly sounds that way.
19 Q. All right. So, for instance, with respect
20 to lung cancer, they didn't look to see whether a lung
21 cancer that had been diagnosed by a doctor was not
22 present, did they?
23 A. Well, I don't -- I don't know specifically
24 if that interpretation is addressed here.
25 Q. Well, they are looking at diseases -- first

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Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 of all, they are looking at a variety of situations.
2 This isn't an article specific to lung cancer, is it?
3 A. No.
4 Q. Okay. And they are saying that they are
5 looking at autopsy now to see whether a disease present
6 at autopsy was diagnosed clinically, correct?
7 A. That's correct.
8 Q. All right. So they are looking to see if
9 something was missed first, right?
10 A. That appears to be true.
11 Q. All right. They are not looking to see if
12 something was overdiagnosed, are they?
13 A. Apparently not.
14 Q. Okay. So they are looking at
15 underdiagnosis, in layman's terms; is that right?
16 A. Yes.
17 Q. Okay.
18 A. An example was, if I recall correctly,
19 pulmonary emboli --
20 Q. All right.
21 A. -- which are underdiagnosed.
22 Q. Now, doctor, one other thing that you are
23 referenced in your expert report as anticipating you
24 will testify about, are the multiple risk factors
25 associated with pulmonary, oral laryngeal, bladder, and

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1 other cancers. Now, you talked about some risk factors
2 previously for lung cancer, and we went through those.
3 With respect to oral laryngeal cancer, what are the
4 other risk factors associated with that?
5 A. I think all of the same --
6 MR. SHEPPARD: Okay. Excuse me. I didn't
7 mean to intrude. What is the number of that disclosure
8 statement?
9 MR. WESTBROOK: 4.
10 MR. SHEPPARD: 4. I am sorry for being in
11 the middle of that question and answer.
12 A. That's okay. I think the same items, and
13 also probably viruses.
14 Q. Have you ever seen a case of oral laryngeal
15 cancer that you thought was due to a virus?
16 A. Oh, I have seen some that could be. There
17 are none that I actually thought were, because I didn't
18 know.
19 Q. Is it fair, doctor, that that's just not
20 something you do, determine what causes disease; that
21 that's something that other physicians get involved?
22 A. Well, it depends upon what the disease is.
23 For example, gunshot wound through the head is
24 something I diagnose fairly commonly.
25 Q. It is not a disease, is it?

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1 A. I would say it's a form of disease, yeah.
2 You can do epidemiological studies and things like that
3 on that too. Anything that produces a condition which
4 there is a reduced state of health or fatality can be
5 interpreted as a disease. It is just a matter of
6 taste.
7 Q. Somebody hit by a car, is that a disease
8 that they have acquired in your definition?
9 A. Well, it is not a disease in the sense of
10 an infectious disease or a naturally occurring disease,
11 but it's a disease and has all sorts of disease
12 consequences too, disabilities and subsequent
13 infections and things of that character.
14 Q. If someone jumps off a building and splats
15 themselves on the sidewalk, have they suffered a
16 disease on the way down?
17 A. What do you have in mind?
18 Q. Any disease you would identify that person
19 as having.
20 A. Well, that sounds like you are postulating
21 suicide. And suicide has certainly been viewed in
22 context of disease, prevention, cause, manners,
23 consequences. It has the same sorts of parameters
24 as. . .
25 Q. Do you distinguish between traumatic injury

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1 and disease in your practice?

2 A. Well, I call it what it is. It's a

3 traumatic injury. I say what it is.

4 Q. Is gunshot wound a traumatic injury or a

5 disease?

6 A. It's both.

7 Q. It's both?

8 A. Uh-huh.

9 Q. Is a knife attack, stab somebody in the

10 chest, is that a traumatic injury or disease?

11 A. Well it can be viewed in various contexts.

12 It can be viewed as a criminal act. It can be viewed

13 as a disease. It can be viewed as an injury. It

14 depends on one's perspective. There are

15 epidemiological studies of suicides and homicides

16 and. . .

17 Q. Now, back to oral laryngeal cancer.

18 Doctor, are there any other risk factors that you can

19 think of other than what you've given me previously for

20 lung cancer?

21 A. Oh, I think I mentioned viral infections.

22 We discussed that.

23 Q. Okay. And oral laryngeal, what area of the

24 body does that refer to?

25 A. The mouth and the voice box and the upper

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Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 airway, orodigestive tract, the upper portion.
2 Q. In the case of a smoker, are those organs
3 all organs that are in contact with cigarette smoke
4 during the process of smoking a cigarette?
5 A. Well, if it gets to that level, yes, of
6 course.
7 Q. All right. Next you have listed bladder
8 cancer as a cancer for which you are going to testify
9 about multiple risk factors. What do you think the
10 risk factors are for bladder cancer?
11 A. I think factors are as we mentioned
12 before. Infections. As a matter of fact there are
13 places in the world where parasitic infection is a very
14 common cause of bladder cancer.
15 Q. Does that include anywhere in the United
16 States?
17 A. Well, the place I think of is -- the best
18 illustration from which literature comes is Egypt. I
19 don't believe I have seen a case in the United States.
20 Certainly industrial chemical exposures. I
21 wouldn't exclude smoking as a factor.
22 Q. Have you seen literature linking smoking to
23 bladder cancer?
24 A. I think I probably have.
25 Q. Doctor, prior to first being contacted in

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1 connection with the tobacco and smoking cases, did you
2 pay any particular attention to the literature on
3 cigarette smoking and disease?
4 A. No.
5 Q. Since you have been contacted, at least
6 starting last fall and have been starting to correspond
7 and bill the Shook, Hardy firm, have you paid any
8 particular attention to the medical or scientific
9 literature on smoking and disease other than the
10 articles that you have in front of you?
11 A. No.
12 Q. Now, finishing up this sentence of your
13 disclosure, it says you are going to talk about
14 multiple risk factors associated with other cancers.
15 What other cancers do you expect to talk about?
16 A. I don't have any expectation. I just don't
17 know.
18 Q. Do you have any other cancers which you
19 have reviewed literature to see if there are multiple
20 risk factors?
21 A. No.
22 Q. Can you tell me any other cancers, sir,
23 that have been linked in the medical literature about
24 smoking about which you are going to discuss other risk
25 factors?

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1 A. Well, that's really not what I intend to
2 do. What I intend to do is review slides and review
3 case materials and attempt to make the best possible
4 diagnosis.
5 Q. All right, sir. Now, the next sentence of
6 your disclosure says that, further, Dr. Willey is
7 expected to testify that each individual cancer
8 patient's medical condition is unique and complex and
9 requires thorough examination of all variables to
10 assure accuracy. Do we agree that thorough examination
11 is necessary in medical care and treatment?
12 A. I am not sure it is necessary in all
13 medical care and treatment. Not only that, but
14 thorough is susceptible to many different
15 interpretations.
16 Q. The word "thorough" is what is in your
17 disclosure. That's why I used it.
18 A. I know, but we are talking about a
19 diagnosis here. You are talking about treatment,
20 medical treatment. In medical treatment, most things,
21 neglecting them, quite to the contrary of thorough
22 medical treatment, is frequently just as beneficial as
23 treatment. A case in point is the common cold.
24 Q. Have you come up with a cure for the common
25 cold, doctor?

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1 A. I don't have.
2 Q. Okay.
3 A. On the other hand, I am not aware that
4 there is one available in mainstream medicine that is
5 shown to work.
6 Q. Are you familiar with the cure rates for
7 lung cancer?
8 A. Only in very general terms, and it depends
9 entirely upon what lung cancer and where you are
10 talking about and who is doing it and things of that
11 sort, and how you select your population.
12 Q. All right. Is one type of lung cancer more
13 curable than another?
14 A. Probably. I'd say that very limited lung
15 cancer in the periphery, where it is resectable, has
16 probably a better outlook than those that are more
17 advanced that are central. But there are a great
18 number of variabilities.
19 Q. Isn't that true for a lot of diseases, that
20 the earlier you catch the disease, the more likely you
21 are to cure it?
22 A. That sounds like a reasonable general
23 proposition. There are certainly specific exceptions.
24 Q. All right. Now, in understanding the
25 parameters you have put on your knowledge about it, can

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1 you tell me what's the approximate cure rate for any of
2 the types of lung cancer that are occurring today?
3 A. I would say it's discouraging. It's not
4 good.
5 Q. What would you put on it, what percentage?
6 A. I wouldn't.
7 Q. Would you put a percentage on any of the
8 cell types?
9 A. No. All I could do is tell you the general
10 knowledge I have already given you, which is that
11 they -- peripheral lesions that are adenocarcinomas are
12 probably better than the central ones that are other
13 cell types, and the size probably is of some
14 importance.
15 Q. And your --
16 A. It is discouraging for all of them.
17 Q. In your view, doctor, can cigarette smoke
18 be inhaled into the periphery of the lung?
19 A. I don't know that I have ever investigated
20 that. I have never bothered to try to read it.
21 Q. Okay. Doctor, have you done any reading to
22 determine whether the type of cancer in the United
23 States males has shifted in proportion to the
24 decreasing tar levels in cigarettes?
25 A. Well, I have seen comments about that in

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1 the literature. I have done nothing to verify it. I
2 don't know that it's correct. I just don't know.
3 Q. What comments have you seen in the
4 literature about that?
5 A. That with the decrease of combustible
6 materials, that the movement has been away from central
7 lesions to peripheral lesions.
8 Q. Does that seem logical to you, sir?
9 A. Well, it sounds like an explanation. I
10 don't know whether it's logical or not. The question
11 is whether it's correct or not, and I don't know.
12 Q. I am asking you, from your experience,
13 whatever that may be, do you think it's a logical
14 explanation?
15 A. I just -- it sounds like it has some sort
16 of semblance of merit. Whether it is correct or not is
17 another matter. I don't know.
18 Q. Again, it's not something that you have
19 studied?
20 A. That's correct.
21 Q. Okay. Doctor, let's turn over to the next
22 page, if we could, of your curriculum vitae.
23 A. Uh-huh.
24 Q. You have got a paragraph which lists your
25 current activities, including your private practice of

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1 forensic medical evaluation, and we have discussed that
2 in some detail. Then you listed as on the department
3 of pathology at the Palms of Pasadena Hospital that you
4 were on the active staff from '67 to '85 and you are
5 now on the consulting staff. What is the difference
6 there, sir? In 1985 how did your status change other
7 than the change in title?
8 A. There was a group of pathologists. I was
9 one of three. And in mid 1985 I chose to leave. And
10 the older member of the group retired. I went to a
11 private office, and I have been doing consultation
12 largely since.
13 Q. Okay. So from 1985 to the present, you
14 have been consulting on litigation matters or other
15 types of matters?
16 A. Well, any type of medical problem. It
17 doesn't matter whether it's litigation or whatever it
18 is. By the way, there are alternative methods of
19 dispute resolution that involve medical issues that
20 have nothing to do with litigation.
21 Q. When you are talking about alternate
22 methods of dispute resolution, are you --
23 A. Arbitration.
24 Q. -- talking about panels, arbitrations
25 panels?

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1 A. Sure. And I have been a hearing officer
2 for determination of privileges for physicians and
3 things of that character.
4 Q. Okay. Would you say that your involvement
5 in matters that have either come to litigation or may
6 be involved in litigation is greater now than it was
7 when you went on to be a consulting staff member of the
8 Palms Hospital in 1985?
9 A. Well, my practice has been pretty much the
10 same since 1985. It's more since '85 than it was prior
11 to 1985.
12 Q. So that since 1985, is it accurate that a
13 large percentage of your activity has involved matters
14 that are either in litigation or you are consulting
15 with lawyers on matters that may get into litigation?
16 A. That sounds correct.
17 Q. Okay. By the way, does the Palms of
18 Pasadena Hospital have a no-smoking policy?
19 A. Yes.
20 Q. Do you think that's a good policy for a
21 hospital to have?
22 A. Yes.
23 Q. Doctor, can you sketch for me, from the
24 time you finished medical school, how your career
25 advanced and generally what you did over the years and

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1 bracket it in some time?

2 A. All right. I graduated from medical school

3 in 1958. I was from the outset interested in

4 pathology. That's effectively all I have done, is

5 pathology, although there are probably no physicians

6 that are not required to adapt to circumstances and

7 practice different things. I trained in pathology

8 first at Duke University and subsequently University of

9 Michigan; went into practice in 1963; was a medical

10 examiner for Duval County and several surrounding

11 counties in Florida, Jacksonville environs. In 1967 I

12 left and went from the place I was in Jacksonville or I

13 should say I also was a pathologist for the University

14 Hospital. It had a different name at that time.

15 That's what the successor name is.

16 And I went to the Palms of Pasadena

17 Hospital. I became largely a hospital pathologist,

18 supervised a blood bank, did anatomical pathology. By

19 virtue of the experience I had had as a medical

20 examiner, I continued to have steady, although at times

21 discontinuous, stream of consultation.

22 Probably beginning in the mid '70s I began

23 to have more and more cases from different people and

24 insurance companies and things of that sort, and so I

25 had a part-time commitment in medical consultation.

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1 And in mid 1985 I simply had enough of that so I had to
2 make a practical choice as to whether I would stop that
3 and just work at the hospital, because it got to be so
4 much time that I couldn't routinely do it; or go a
5 private practice and do consultation alone.
6 I think probably one of the determining
7 factors at that point was that one of the older people
8 in our group of three pathologists that had been
9 together for over 20 years was nearing retirement age,
10 and the management of the hospital looked to me to be
11 the successor and the director of pathology, which is
12 really not what I wanted to do. I just am not a person
13 that wishes to manage a large number of people. That's
14 not what I choose to do. And so I left the group and
15 went to a private office, which I have had ever since,
16 and I do consultation.
17 Initially my position was principally with
18 major insurance companies. A man who at that time
19 handled all of the claims management for St. Paul in
20 Tampa told me that I should not worry, that he would
21 keep me busier than I could possibly be as a hospital
22 pathologist, in looking at their claims. And within a
23 very short interval after I left and went to an office,
24 he took a golden parachute and retired, and then
25 St. Paul withdrew from the market and -- but I had a

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1 large number of other people that sent things to me,
2 and so that's what I have done ever since.
3 Q. Okay.
4 A. Completely happy at it.
5 Q. Doctor, have you ever been involved in a
6 lawsuit involving your professional activities? I am
7 not interested in your personal activities.
8 A. You mean have I ever been sued for anything
9 I did professionally?
10 Q. Or have you ever sued anybody in a
11 professional matter?
12 A. Well, I have never been sued for any
13 professional activity. I do not want you misled
14 because I was at one time an agent for process of
15 service or nominee or something or some legal term for
16 it for the hospital corporation, and I used to get
17 bushel basketfuls of things that named me as a nominee
18 or something.
19 Also at one time I was on a board of
20 directors. After I left the board of directors, I was
21 sued for activities that the board had done after I had
22 left. That's all I can think of on the side where I
23 have been sued.
24 Professionally I have never sued anyone
25 with the exception of debt collection, and there are

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1 to hospitals, different medical facilities, and
2 doctors' offices. And it had been acquired by Medfield
3 Corporation long before I was on the board. I
4 ultimately got that in shape and sold it.
5 Q. Did you have any ownership interest in the
6 Surgical Equipment Corporation?
7 A. No. It was a wholly owned subsidiary.
8 Q. Doctor, are there presently laws that
9 prevent physicians from having laboratory analyses and
10 tests conducted by companies or laboratories in which
11 they have a financial interest?
12 A. Well, I, of course, do not know all the
13 laws, federal, state, and otherwise. Conflicts of
14 interest are something that are in my judgment things
15 best avoided. It looks like a conflict of interest to
16 me.
17 Q. There is something mentioned here called
18 Cory Medical Enterprises, Inc. What was that?
19 A. That was another wholly owned subsidiary
20 that operated office buildings, principally medical
21 office buildings, but we had other tenants as well,
22 attorneys, a podiatrist or two, dentist maybe.
23 Professional office buildings.
24 Q. All right. And you also listed one time
25 you were a guest lecturer at the University of Florida

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1 Law School and Stetson University Law School. When was
2 that?
3 A. Well, I don't know when they were. It's
4 been years. I think I appeared a couple times, three
5 times maybe at Florida and probably about twice at
6 Stetson.
7 Q. Did you ever lecture on anything having to
8 do with tobacco and health?
9 A. No.
10 Q. Up to today have you ever lectured to
11 anybody on issues involving tobacco and health?
12 A. Not to my knowledge. No.
13 Q. You were also listed as a contracted
14 expert, Florida Department of Professional Regulation.
15 What is a contracted expert?
16 A. Well, I am glad that that's been corrected,
17 because in a prior edition it went, for a number of
18 years, it was misspelled "contacted" expert.
19 A contracted expert is any expert that the
20 Florida Department of Professional Regulation engages
21 because they enter into contracts with all of them.
22 Q. Okay. And what services did you perform
23 for the Florida Department of Professional Regulation?
24 A. Case review. One occasion I made an
25 appearance and testified in their behalf.

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1 Q. Is this in connection with a physician's
2 license being put at risk?
3 A. Yes.
4 Q. Okay. Did the matter in which you have
5 testified involve over-utilization of services?
6 A. I don't think I would categorize it as
7 that, no.
8 Q. Would you categorize it as malpractice?
9 A. In part.
10 Q. Did it involve any medical fraud?
11 A. I do not know how the trier of fact ruled
12 on that so I can't answer that. But from my
13 perspective, I thought so.
14 Q. Did it involve in any way the issue of
15 cancer or cancer diagnosis?
16 A. Well, this has been some years ago. And my
17 recollection is less than perfect, but my recollection
18 is no.
19 Q. Were you a contracted expert for the
20 Florida Department of Professional Regulation on more
21 than one occasion?
22 A. Yes.
23 Q. Okay. On approximately how many occasions?
24 A. A small number. Two, three, maximum.
25 Q. Okay. To your knowledge did any of the

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1 other situations involve issues of cancer, cancer
2 diagnosis, or cancer treatment?
3 A. I don't recall that. I think not. But on
4 the other hand, I have such an imperfect recollection
5 of what they were that I don't -- I am not completely
6 confident that's correct.
7 Q. You are listed as a member of the grievance
8 committee of the Florida Bar. When did you serve on
9 the grievance committee of the Florida Bar?
10 A. Was the question when or why?
11 Q. When.
12 A. When. It was a three-year period. I
13 believe it was approximately beginning 1989.
14 Q. Okay. And what services --
15 A. Maybe it was 1990.
16 Q. And what services did you render to the
17 Florida Bar on grievance committee?
18 A. I was a member of the committee. I
19 investigated a number of cases, and on one occasion I
20 actually prosecuted one.
21 Q. Were you prosecuting attorneys?
22 A. Yes. Not attorneys, just one. Singular.
23 Q. When you say you prosecuted it, --
24 A. Yeah.
25 Q. -- were you appointed as a prosecutor for

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1 the committee to present the committee's case against
2 the attorney?
3 A. That's correct.
4 Q. All right. Did the case involve some claim
5 of legal malpractice?
6 A. I wouldn't style it as legal malpractice,
7 no.
8 Q. What would you call it?
9 A. I think it was much more severe than that.
10 And more than that, I really don't want to delve into
11 this; because I was appointed by the Supreme Court and
12 there is a restrictive order about not disclosing
13 information about that. I don't mind telling you I did
14 it, but I really don't want to go further than the
15 that.
16 Q. Okay. Maybe we can end this here, and let
17 me ask you the question --
18 A. The question, if I began -- If I began to
19 give you more details, it will be impossible to
20 conform.
21 Q. Okay. Let me just ask you this and see if
22 we can end this aspect of it. Did any of your
23 activities as a member of the Florida Bar grievance
24 committee involve issues of cancer or cancer diagnosis
25 or treatment?

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1 A. No.

2 Q. Doctor, I notice on the next page that you

3 have active medical license in Michigan, Florida, and

4 North Carolina. Is that current as of today?

5 A. That's my best belief.

6 Q. Do you practice medicine in Michigan?

7 A. No.

8 Q. When is the last time you practiced

9 medicine in Michigan?

10 A. Probably 1963.

11 Q. Is there a particular reason you keep your

12 license active there?

13 A. That's a good question. I think it's

14 because it's a license obtained by examination that is

15 probably transferable to more than 45 states.

16 Q. Now, you also have a North Carolina active

17 license. Do you presently practice medicine in North

18 Carolina?

19 A. No.

20 Q. When is the last time you actively

21 practiced medicine in North Carolina?

22 A. I don't recall anytime after I left Duke

23 University, which was in June 1959, the end of June

24 1959.

25 Q. The same question with respect to that. Is

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there any particular reason that you are keeping that license active?

A. Well, I have family in North Carolina, and it is a possible place I would go if I wanted to. There is no real disadvantage to doing that, other than the fact it costs $75 or $100 a year or something like that.

Q. And you have a Georgia license listed as inactive. When is the last time you practiced medicine in Georgia?

A. Probably about 1967. There were some small hospitals in south Georgia. Maybe a little earlier than that. There were some little hospitals in south Georgia that I would occasionally cover.

Q. Doctor, have you ever testified in court in any matter outside of the state of Florida?

A. Yes.

Q. Okay. When is the last occasion, sir?

A. I just don't remember. There may have been other occasions. The last one I can remember with some precision is the weekend Nicole Simpson was murdered. It was in St. Louis.

Q. What type of case was that?

A. That was a malpractice case.

Q. Did the malpractice occur in this area?

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1 A. No.

2 Q. Did the malpractice affect somebody who

3 lived in this area?

4 A. No.

5 Q. How did you come to get involved in the

6 St. Louis malpractice case?

7 A. The attorney involved with the case knew

8 someone that recommended me. And he suggested to his

9 son he call me. He did.

10 Q. All right. Prior to that time, can you

11 recall when was the last time you testified out of

12 state in any matter?

13 A. Well, I may have testified after that out

14 of state. I just don't recall that that's -- that's

15 true. I just -- I don't know. I have calendars and

16 records. I could go back and find out, but I don't

17 recall.

18 Q. Have you ever testified in the State of

19 Mississippi courts?

20 A. I am reasonably sure I haven't. I think I

21 had a case at one time in Mississippi, but I don't

22 believe there was ever even a deposition.

23 Q. Have you ever been to the state of

24 Mississippi?

25 A. Well, I passed through. I have never

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Source: https://www.industrydocuments.ucsf.edu/docs/qsfl0001

1 stopped there for any length of time.

2 Q. Do you recall ever passing through Laurel,

3 Mississippi?

4 A. No.

5 Q. Do you have any relatives in Mississippi?

6 A. I don't know of any. There may be, but I

7 don't know of any.

8 Q. You list a number of societies and

9 certifications. Are those memberships and

10 certifications all current as far as you know?

11 A. To the best of my knowledge, yes.

12 MR. WESTBROOK: Do you want to take a break

13 for a few minutes?

14 MR. SHEPPARD: Sure.

15 (Recess)

16 BY MR. WESTBROOK:

17 Q. Okay. Doctor, back to your curriculum

18 vitae for a minute. We are on the second page.

19 A. I don't know what I did with it. Some of

20 it. Just a moment. Here it is.

21 Q. Doctor, I don't see listed on your C.V. any

22 publications in scientific and medical journals. Have

23 you published any scientific or medical articles in

24 peer review journals?

25 A. I don't know whether they are anything that

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1 has appeared in a peer review journal. That seems to
2 be language that has evolved fairly recently. I'm sure
3 they have all had a review process. Whether that's
4 peer review or not is another matter. I don't know.
5 Q. Have you, I take it, then, published
6 articles in some journals?
7 A. Well, yes. But I don't want you misled. I
8 am generally one of several contributors, not the
9 exclusive --
10 Q. Do you --
11 A. Not the exclusive author.
12 Q. Do you know what a peer review journal is,
13 sir?
14 A. Yes.
15 Q. All right. What is the last article that
16 you recall authoring or co-authoring that appeared in
17 some journal?
18 A. It's approximately 1985 or 1986.
19 Q. What was the subject if you remember?
20 A. I was a minor contributor in my judgment.
21 The subject was microvascular repair.
22 Q. Okay. Since you have gone into your
23 private consulting practice, have you prepared or
24 submitted any articles to journals?
25 A. No.

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1 Q. Prior to that time did you participate in
2 any article that dealt with tobacco, smoking, and
3 cancer?
4 A. I don't think so. I don't have any
5 recollection of that.
6 Q. Okay. Do you have any recollection of
7 participating in any article that dealt with any aspect
8 of tobacco?
9 A. The same answer, no, I don't think so. I
10 certainly don't have any recollection of being in any
11 way involved with that.
12 Q. Do you have any recollection of having
13 participated in any article that dealt with lung
14 cancer?
15 A. I don't have recollection. I don't think I
16 have.
17 Q. Doctor, have you talked with any other
18 experts who have been consulting with the tobacco
19 companies in this case?
20 A. Not to my knowledge. If I have, they
21 haven't been identified to me in that way. I do talk
22 with other pathologists and some other kinds of
23 doctors.
24 Q. Are you aware of who any of the other
25 experts are who have been listed by the tobacco

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1 companies in this case?

2 A. No.

3 Q. Doctor, are you familiar with the concept

4 of staging as it's used in connection with lung cancer

5 diagnosis?

6 A. In general, every time I am required to do

7 anything about that, I simply look at the information

8 on staging. It is not something I remember.

9 Q. Okay. And what is the concept of staging?

10 A. Concept of staging is to place patients

11 into groups so as better to define prognosis and

12 treatment.

13 Q. All right. Is there a staging designation

14 for metastatic cancer?

15 A. Yes.

16 Q. And are the staging classifications

17 standardized as far as you know in this country?

18 A. Well, there is a joint tumor registry or

19 joint something or other that publishes a book

20 periodically that has the techniques. There are --

21 there are more than one form of staging for things, and

22 not everybody does it the same way.

23 Q. Are there different standardized protocols

24 for staging for lung cancer?

25 A. I am sure there are. I don't know them

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1 all.

2 Q. Do you know of more than one?

3 A. No, I don't, but I think there probably is

4 more than one.

5 Q. Have you heard of a group called the IARC?

6 A. What does that stand for?

7 Q. It means International Association of

8 Research on Cancer.

9 A. No, I don't know them.

10 Q. Doctor, you've said you never stopped in

11 Mississippi. I take it you ever never consulted with

12 any governmental entity in Mississippi on any matter;

13 is that correct?

14 A. I think I was hired by a sheriff's

15 department in some county in Mississippi at one time.

16 Q. For what?

17 A. Consult on a case.

18 Q. What kind of case, sir?

19 A. I don't know the details of it. It was a

20 person that died in the jail.

21 Q. Was it someone who died in jail suddenly?

22 A. I don't remember all the details. As I

23 say, I think that he died unexpectedly. I don't know

24 how sudden it was but. . .

25 Q. Where in Mississippi was the sheriff?

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1 A. I don't remember.

2 Q. What year was this, sir?

3 A. It was several years ago.

4 Q. Before 1980?

5 A. No. It wasn't before 1980, I'm sure.

6 Q. Okay. Would it have been after you became

7 a private consultant in 1985?

8 A. Yes.

9 Q. I take it that this jail death didn't

10 involve a cancer matter at all, did it?

11 A. No, I don't think so.

12 Q. Doctor, do you subscribe to the

13 constitutional hypothesis regarding lung cancer?

14 A. I am not familiar with what you mean by a

15 constitutional hypothesis.

16 Q. Okay. Doctor, are you familiar with the

17 concept in epidemiology called age standardized

18 statistics?

19 A. No.

20 Q. Do you know what a control is in an

21 epidemiological study?

22 A. Only in general terms.

23 Q. All right. What is your general

24 understanding of the term "controlled"?

25 A. It's a similar population which does not

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1 have the variable present that is being studied.

2 Q. Are you familiar, doctor, with the concept

3 of controlling in an epidemiological study for certain

4 factors?

5 A. No. That's a statistical technique that I

6 just don't apply and have no familiarity with.

7 Q. Doctor, you may have answered this, and if

8 you did, I apologize. But did you tell me whether your

9 societies and certifications are all current

10 memberships?

11 A. I think that was actually asked and

12 answered, and yes is what I think I said. As far as I

13 am aware, they are all current. If I ever overlooked

14 paying dues or something, I am certainly not aware of

15 it.

16 Q. Are you active in any of these societies as

17 an officer, sir?

18 A. No.

19 Q. Do you submit papers or give lectures at

20 any of these society meetings presently?

21 A. No.

22 Q. Are you a member of any of the committees

23 or subcommittees of these societies concerned with

24 tobacco and health?

25 A. No.

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1 Q. Do you know what the position is of any of
2 the societies of which you are a member on tobacco and
3 health?
4 A. Only in a very imperfect way.
5 Q. What is your imperfect understanding of the
6 positions of some of these societies?
7 A. Well, I say that the position of the
8 American Medical Association is one of opposition to
9 tobacco consumption.
10 Q. Do you know of any medical society that
11 supports smoking?
12 A. I don't know one.
13 Q. And do you know of any public health
14 association that supports smoking?
15 A. I don't know one.
16 (Exhibit No. 14 was marked for
17 identification.)
18 Q. If we could, let's mark as the next exhibit
19 a letter from Dr. Willey to Carol Lindgren-Bron of the
20 Shook, Hardy law firm, dated March 5th 1997.
21 Doctor, would you look at your copy of the
22 letter. Is this a letter that you wrote to counsel for
23 the tobacco companies enclosing a copy of a letter that
24 an attorney from my firm wrote to the Florida Society
25 of Pathologists?

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1 A. That certainly appears to be. I remember
2 writing it.
3 Q. Okay. And in your letter to the attorney
4 for the tobacco companies, do you say, after the
5 introductory sentence enclosing the letter, quote, "It
6 is apparent that they are willing to look everywhere to
7 accumulate adverse information", unquote?
8 A. That's what I said.
9 Q. Okay. Now, the letter that the lawyer from
10 our office wrote to the Florida Society of Pathologists
11 asks for a list of your publications, speeches, and
12 letters you have written and any position or policy
13 statement from the association concerning smoking and
14 health, as well as a copy of your membership records,
15 correct?
16 A. Yes. It also continues, "If you have any
17 questions, please do not hesitate to phone me."
18 Q. Did you find that --
19 A. "I look forward to hearing from you in the
20 near future."
21 Q. Do you find it unusual in a letter
22 requesting information to tell the person from whom you
23 are requesting information that if they have a question
24 to call?
25 A. I don't know whether it's usual or unusual.

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1 Q. Okay. What is it about the letter, doctor,
2 that caused you to think that our firm was looking
3 everywhere to accumulate adverse information?
4 A. Well, one thing is my attitude about the
5 Florida Society of Pathologists is that that is such a
6 remote connection that that suggests that, for anyone
7 to reach the Florida Society, they have been lots of
8 places that are more obvious.
9 Q. The Florida Society of Pathologists is the
10 society whose membership you list in your C.V., isn't
11 it?
12 A. Yes.
13 Q. And you practice here in Florida?
14 A. Yes.
15 Q. And is there anything derogatory at all in
16 the letter written by my office to the Florida Society
17 of Pathologists about you as you read it?
18 A. I don't interpret it that way.
19 Q. Okay. Now, your letter to the attorneys
20 for the tobacco company says, "I do not know of
21 anything substantive which discredits me, but I assume
22 they are willing to mischaracterize everything they can
23 find." Why did you assume that we would
24 mischaracterize everything we could find?
25 A. It just seemed like a reasonable

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1 assumption.

2 Q. Do you normally assume that counsel on the

3 other side of a case will attempt to mischaracterize

4 what they find?

5 A. No, not always.

6 Q. All right. Why did you assume it in this

7 instance?

8 A. Because this is one of the few

9 circumstances in which I have ever had anyone that was

10 willing to send out letters to accumulate background

11 information on me.

12 Q. All right. Well, why does the accumulation

13 of background information, though, give you the thought

14 that whatever is located would be mischaracterized?

15 A. Because that's to your advantage.

16 Q. Okay. Have you had any prior exposure to

17 my firm before being involved in this case?

18 A. Not to my recollection.

19 Q. Do you have any reason to believe that my

20 firm would mischaracterize something about you?

21 A. No, not specifically.

22 Q. Okay. Do you regard my firm as an

23 adversary to you in this matter?

24 A. No.

25 Q. Do you regard my firm as having any ill

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1 will toward you in this matter?

2 A. I don't know.

3 Q. Well, as you sit here today, after having

4 been through this deposition, do you have any ill will

5 toward our firm?

6 A. I don't. I don't know how you feel on it.

7 I don't know how your firm feels. That's what you

8 asked me. I have no idea what your feelings are.

9 Q. You wrote in the final sentence of your

10 letter to the counsel for the tobacco companies,

11 "Probably they will do this with all of your

12 witnesses." What was the purpose of writing that

13 sentence?

14 A. Because I think they ought to be aware that

15 that's a likelihood.

16 Q. Okay. You thought that was something that

17 tobacco companies' lawyers should know?

18 A. I wouldn't have written it if I didn't

19 think so.

20 Q. Why did you think they should know that?

21 A. Because they ought to be aware that the

22 possibility exists that people will feel coerced by

23 this type of background inquiry.

24 Q. When --

25 A. I recall one occasion in which I had

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1 A. Well, I am sorry, but I personally think
2 that this sort of effort at accumulating information
3 like that is partially intended to chill witnesses.
4 And they should be aware that that's a reality.
5 Q. And why do you think that accumulating
6 information, as opposed to an FBI agent sitting in
7 front of your door, but accumulating information, is
8 intended to chill a witness?
9 A. I think both do.
10 Q. Why does accumulating information chill the
11 witness?
12 A. Well, I think that this has the collateral
13 purpose of telling an organization of which I belong
14 that I am doing something that they may think is
15 undesirable.
16 Q. You think --
17 A. And that the implicit, if not explicit,
18 expectation is that somebody will express some form of
19 disapproval.
20 Q. And do you think that the Florida Society
21 of Pathologists or some other association would regard
22 your representing or consulting with the tobacco
23 companies as undesirable?
24 MR. SHEPPARD: Let me object to the form of
25 that question as being a double question. Because he

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1 is not representing the tobacco companies.
2 Q. Doctor, so the record is clear, do you
3 believe that the Florida Society of Pathologists would
4 regard it as undesirable that you were -- had agreed to
5 serve as an expert defense witness on behalf of the
6 tobacco industry?
7 A. That's a reasonable expectation.
8 Q. All right. Do you believe serving as an
9 expert witness for the tobacco industry is an
10 undesirable role?
11 A. No. I am completely neutral about it.
12 Facts are facts.
13 Q. Have you informed anyone that you have been
14 retained as an expert on behalf of the tobacco
15 companies?
16 A. Have I informed anyone? Whom is there to
17 inform?
18 Q. Professional colleagues.
19 A. I don't recall having done that. On the
20 other hand, I can't remember going out of my way on any
21 occasion ever to tell a professional colleague of any
22 sort that anybody has engaged me. It just seems
23 needless, gratuitous.
24 Q. Now, doctor, there are some roles in
25 professional life that people are generally proud of.

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1 For instance, I think if the president of the United
2 States asked you to sit on a commission, people might
3 be proud of that and tell people they did it.
4 A. I would refuse --
5 MR. SHEPPARD: Wait. There is no -- I
6 object. There is no question.
7 Q. I didn't even ask you a question yet,
8 doctor.
9 MR. SHEPPARD: Just a statement.
10 A. Oh, sorry.
11 MR. SHEPPARD: Getting late in the day.
12 Q. I am going to continue, okay, doctor?
13 A. I didn't recognize it as a question. Go
14 ahead.
15 Q. No, I hadn't gotten to my question yet.
16 A. Okay.
17 Q. Do you regard your service as an expert
18 witness on behalf of the tobacco companies as something
19 that you are professionally proud of?
20 MR. SHEPPARD: Objection to the form; it is
21 irrelevant; and also to the extent it includes a
22 preamble, it is misleading.
23 A. I just think it's another job in which
24 there are facts that need to be determined and that it
25 needs to be done by someone and needs to be done well.

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1 And if I take any pride in it, it's not in how it turns
2 out and it is not whom I am employed by. It is that I
3 have done the best I can with what I had at what I was
4 asked to do.
5 Q. Okay. With that --
6 A. So the answer is yes, I take professional
7 pride in what I do.
8 Q. Okay. So you are, then, professionally
9 proud to be a witness for the tobacco companies?
10 A. It has nothing to do with the tobacco
11 companies. It has nothing to do with any person or any
12 entity. For example, I have been hired by the capital
13 collateral representative to work on cases for
14 condemned on death row. And it does not mean that I
15 necessarily endorse anyone on death row. It is simply
16 a job that needs to be done and done well. There are
17 people there that don't deserve to be there.
18 Q. Are you aware or have you been told that
19 other experts have refused to be experts for the
20 tobacco industry and that's why you have to do this?
21 A. No.
22 MR. SHEPPARD: Well --
23 Q. Okay. Doctor, let me take a minute. We
24 may be just about done.
25 Doctor, do you have any future

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1 consultations arranged with the tobacco company lawyers
2 on the individual cases that you have looked at some of
3 the records of?
4 A. What do you mean, arranged?
5 Q. I mean, do you have plans to meet next week
6 or two weeks on those cases?
7 A. You mean do I have an appointment to meet
8 them? No.
9 MR. WESTBROOK: Doctor, thank you. That's
10 all the questions I have today.
11 THE WITNESS: Thank you. Certainly nothing
12 personal in my position.
13 MR. WESTBROOK: Doctor, I never --
14 MR. WOHNER: Just to be clear, the doctor
15 said he wants to read and sign the deposition?
16 THE WITNESS: Yes.
17 MR. WOHNER: I think we are not waiving
18 reading and signing.
19 THEREUPON, the deposition of EDWARD N.
20 WILLEY, M.D. was concluded at 4:30 p.m.
21
22
23
24
25

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1 I N D E X

2

3 Page

4 WITNESS/EXAMINATION

5 EDWARD N. WILLEY, M.D.

6 EXAMINATION

7 BY MR. WESTBROOK..... 4

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10 REPORTER'S DEPOSITION CERTIFICATE..... 193

11

12

13 EXHIBITS

14 Exhibit Nos. 1 through 4..... 3

15 Exhibit No. 5..... 61

16 Exhibit No. 6..... 76

17 Exhibit No. 7..... 82

18 Exhibit No. 8..... 95

19 Exhibit No. 9..... 108

20 Exhibit No. 10..... 116

21 Exhibit No. 11..... 119

22 Exhibit No. 12..... 125

23 Exhibit No. 13..... 145

24 Exhibit No. 14..... 179

25

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1 SIGNATURE PAGE

2 I, EDWARD N. WILLEY, M.D., have read the
3 foregoing deposition given by me on March 27, 1997, in
4 St. Petersburg, Florida, and the following corrections,
5 if any, should be made in the transcript:

6 PAGE LINE CORRECTION AND REASON THEREFOR

7
8
9
10
11
12
13
14
15
16

17 Subject to the above corrections, if any,
18 my testimony reads as given by me in the foregoing
19 deposition.

20 SIGNED at _____, Florida, this
21 _____ day of _____ , 19___.

22
23
24 _____
EDWARD N. WILLEY, M.D.
25

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1 CERTIFICATE OF REPORTER OATH

2 STATE OF FLORIDA
COUNTY OF SARASOTA

3

4

5 I, the undersigned authority, hereby
6 certify that the witness named herein personally
7 appeared before me and was duly sworn.

8

9 WITNESS my hand and official seal this
10 4th day of April 1997.

11

12

13

14 Donna L. Peterson

Donna L. Peterson, RDR
15 Notary Public - State of Florida
My Commission No. CC482473
16 Expires: 8/7/99

17

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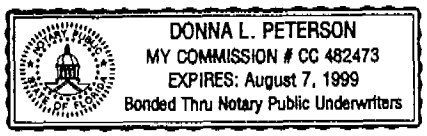

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1 REPORTER'S DEPOSITION CERTIFICATE

2

STATE OF FLORIDA
3 COUNTY OF SARASOTA

4 I, DONNA L. PETERSON, Registered Diplomate Reporter and Notary Public in and for the State of
5 Florida at large, hereby certify that the witness appeared before me for the taking of the foregoing
6 deposition, and that I was authorized to and did stenographically and electronically report the
7 deposition; and that a review of the transcript was requested; and that the transcript is a true and
8 complete record of my stenographic notes and recordings thereof.

9

I FURTHER CERTIFY that I am neither an
10 attorney nor counsel for the parties to this cause nor a relative or employee of any attorney or party
11 connected with this litigation, nor am I financially interested in the outcome of this action.

12

DATED THIS 4th day of April 1997, at
13 Sarasota, Sarasota County, Florida.

14

15

16 Donna L. Peterson
DONNA L. PETERSON, RDR
17 My Commission No.: CC482473
Expires: 8/7/99

18

19

20 DONNA L. PETERSON
MY COMMISSION # CC 482473
21 EXPIRES: August 7, 1999
Bonded Thru Notary Public Underwriters

22

23

24

25

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